Agenda – Public Accounts Committee

Meeting Venue:

Committee Room 3 – Senedd

Meeting date: 4 February 2019

Meeting time: 13.15

For further information contact:

Fay Bowen

Committee Clerk

0300 200 6565

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(Pre-meeting)

(13.15 – 13.30)

1 Introductions, apologies, substitutions and declarations of interest

(13.30)

2 Paper(s) to note

(13.30 – 13.35)

2.1 Medicines Management: Letter from the Welsh Government (17 January 2019)

(Pages 1 – 16)

3 Governance Review of Betsi Cadwaladr University Health Board: Lessons Learnt: Evidence Session with North Wales Community Health Council

(13.35 – 15.05) (Pages 17 – 168)

Research Briefing

PAC(5)-03-19 Paper 1 – North Wales Community Health Council – Comments on the Public Accounts Committee report "Wider issues emanating from the governance review of Betsi Cadwaladr University Health Board – February 2016"

PAC(5)-03-19 Paper 2 – North Wales Community Health Council – Briefing Pack

Geoff Ryall-Harvey, Chief Officer, North Wales Community Health Council

Mark Thornton – Chair of the North Wales Community Health Council

Garth Higginbotham - Vice-Chair of the North Wales Community Health Council

4 Motion under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business:

(15.05)

Items 5, 6, 7 8 & 9

5 Governance Arrangements at Betsi Cadwaladr University Health Board: Lessons Learnt: Consideration of evidence received

(15.05-15.25)

6 Primary care out-of-hours service: Feedback from Member's Engagement with Out-of-Hours Services

(15.25 - 15.40)

7 Scrutiny of Accounts 2017-18: Consideration of the draft Report

(15.40 - 16.15) (Pages 169 - 231)

PAC(5)-03-19 Paper 3 - Draft Report

8 The Welsh Government's youth discounted bus fare scheme - MyTravelPass: Auditor General for Wales' Report

(16.15 - 16.30) (Pages 232 - 287)

Research Briefing

PAC(5)-03-19 Paper 4 - Auditor General for Wales Report

PAC(5)-03-19 Paper 5 - Welsh Government response

9 Expenditure on agency staff by NHS Wales: Auditor General for Wales' Report

(16.30 -16.45) (Pages 288 - 324)

Research Briefing

PAC(5)-03-19 Paper 6 - Auditor General for Wales Report

Agenda Item 2.1

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Nick Ramsay AM
Chair
Public Accounts Committee
National Assembly for Wales
Cardiff Bay
Cardiff
CF99 1NA

Our Ref: AG/AE

17 January 2019

Dear Mr Ramsay,

Medicines Management

Further to my letter of 16 August, it was agreed I would write again in to the Committee in January with a final update on the Welsh Government's response to the Medicines Management report.

I trust the additional information in Annex A clarifies the position in relation to the particular recommendations you highlight.

Yours sincerely

Dr Andrew Goodall

cc: Andrew Evans, Chief Pharmaceutical Officer, Welsh Government
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Response to the recommendations contained in the report from the National Assembly for Wales Public Accounts Committee entitled Medicines Management - Annex A

Llywodraeth Cymru
Welsh Government

Recommendation	Welsh Government response	Update	Completed/ Ongoing
Recommendation 1. The Committee recommends that the Welsh Government produce an annual report detailing information of improvements in medicines management across all the Health Boards, to increase accountability and ensure that the profile of medicines management remains high on the agenda of Health Boards. **Accept**	We do not consider an additional annual report published by Welsh Government is the most appropriate means to achieve the Committee's objectives. As an alternative to an additional annual report published by the Welsh Government, we will require the All Wales Medicines Strategy Group (AWMSG) to undertake work to inform and develop their existing annual report and quarterly reporting of progress against national prescribing indicators to ensure the content and format is more relevant and accessible to Board members of NHS bodies. This work will be completed in time for the publication of AWMSG's 2018-19 annual report. In addition we will continue to develop medicines management indicators as part of the NHS Wales Delivery Framework and hold NHS bodies to account for performance against the Framework.	As previously advised, this work will be completed in time for the publication of AWMSG's 2018-19 annual report, expected to be published in September 2019. Medicines management indicators are included as part of the NHS Wales Delivery Framework; NHS bodies' are held to account against the framework.	Ongoing until AWMSG 2018-19 annual report published Ongoing

Recommendation	Welsh Government response	Update	Completed/ Ongoing
Recommendation 2. The Committee recommends that the Welsh Government issue a national directive that all Health Boards need to develop campaigns to raise the profile of medicines management. These campaigns should be based on examples of best practice from the existing campaigns which have been built up from a local level. **Accept**	The Welsh Government is providing funding to health boards to support communication activities which promote new models of primary care and its benefits for citizens. Citizen responsibility including their responsibilities in respect of prudent use of medicines is a core component of that work. We recognise there have already been successful local campaigns which raise the profile of medicines management in particular the *Your Medicines Your Health* campaign in Cwm Taf University Health Board. In addition to the funding being provided to health boards for primary care, we will make a further £50,000 available to health boards in 2018-19 to undertake local activity to promote the most successful elements of the *Your Medicines Your Health* campaign.	Funding of £100,000 over a 2 year period (2018-19 and 2019-20) has been provided to Cwm Taf University Health Board to oversee an All-Wales campaign based on their successful Your Medicines Your Health campaign to fund a campaign co-ordinator, communications activity and production of resources. The campaign's aim, with its message 'Take them if you can, tell us if you can't' is to prompt people who may not take their medication, for whatever reason, to speak to their doctor or pharmacist.	Completed
Recommendation 3. The Committee recommends that the Welsh Government sets out a plan to maximise the use of pharmacy resource, including developing the modules for delivery in	We will work with the NHS Wales Informatics Service and health boards to develop further modules within Choose Pharmacy which support community pharmacists delivering an increased range of clinical services. To that end further modules are in development within	Officials are monitoring the take up of independent prescribing courses and the independent prescribing pathfinder sites in community pharmacies over the two year funding period – to be	Ongoing – funding provided to March 2020

Recommendation	Welsh Government response	Update	Completed/ Ongoing
choose pharmacy and enabling independent pharmacists. This plan should build on the recommendations in the Royal Pharmaceutical Society report. **Accept**	Choose Pharmacy to support the national emergency contraception service and a sore throat test and treat service from community pharmacies. It is intended that both modules will be available later in 2018-19. In addition to modules supporting service commissioning, Choose Pharmacy is being developed to improve communication between community pharmacies and other NHS providers, these developments include the transfer of electronic letters from pharmacies to GPs and secondary care (to be delivered by March 2019), and systems to allow Wales' NHS 111 service to refer appropriate patients to a community pharmacy. Independent prescribing by pharmacists has grown considerably in recent years, facilitated by the increase in GP practice based roles. In January 2018 in primary care, 65 pharmacist independent prescribers issued 50,484 prescriptions from 111 GP practices. This represented an increase of 150 percent in the number of active pharmacist independent prescribers, a 640 percent increase in	completed March 2020. Updated position from all Health Boards as at December 2018 is provided at Annex A.	

Recommendation	Welsh Government response	Update	Completed/ Ongoing
	pharmacist prescriber prescriptions and a 171 percent increase in GP practices utilising pharmacist independent prescribers in the two years since January 2016. In April, we confirmed funding for up to 100 community pharmacists to take up independent prescribing courses in the next two years and to provide funding to health boards to support establishing up to 40 independent prescribing pathfinder sites in community pharmacies. We will ask the Welsh Pharmaceutical Committee to work with stakeholders including the Royal Pharmaceutical Society to develop a plan describing the future roles of pharmacy professionals in Wales and the steps to be taken by all stakeholders to maximise their use. The plan will be completed in the early part of 2019-20.	The Welsh Pharmaceutical Committee's plan will be finalised by 1 April 2019.	Ongoing – to be completed 1 April 2019
Recommendation 6. The Committee recommends that the Welsh Government amends the Community pharmacy contract to achieve	In October 2016, I announced the Welsh Government's intention to make new contractual arrangements for community pharmacies which ensure in future they provide a greater range of clinically	Significant progress has been made in 2018-19 to realise the potential of the community pharmacy sector in Wales.	Ongoing – to be completed February 2019

Recommendation	Welsh Government response	Update	Completed/ Ongoing
the necessary changes to release the full potential of the pharmacy sector and realise the aim of moving from a quantity to a quality based set of arrangements, and implementation timescales. **Accept**	focused services and demonstrate a commitment to improving service quality. In 2017-18, we introduced new contractual arrangements which included 1) increased and ring-fenced funding for local commissioning of additional clinical services by health boards; 2) funding to support collaborative working between pharmacists and other healthcare professionals; and 3) a new quality and safety scheme for community pharmacies. Changes were funded through redistribution of £3.5million of contract funding from volume driven arrangements (i.e. dispensing) to the new quality focused elements. For 2018-19, agreement has been reached with Community Pharmacy Wales to redistribute a further £3million to support further service commissioning, to strengthen and expand the collaborative working and quality and safety schemes and to support developing the community pharmacy workforce. We will continue to transition to new community pharmacy contractual arrangements through annual	The funding to support commissioning and delivery of value adding clinical services from community pharmacies has been increased by over 75% since 2016-17 (from £3.9m to £6.9m). This has resulted in both the delivery of a wider range of services from pharmacies; and more consistent access to established services including the national common ailment, influenza vaccination, and smoking cessation services which are now routinely available in all health boards. By March 2019 the Welsh Government will have funded the training of over 45 community pharmacists as independent prescribers. In 2019-20 these pharmacists will use their prescribing training to improve access to treatment for an extended	

Recommendation	Welsh Government response	Update	Completed/ Ongoing
	negotiations with new arrangements fully in place by the end of 2020-21.	range of minor ailments and to routine contraception from community pharmacies across Wales. Changes to the pharmacy collaboration and quality and safety schemes, which we introduced in 2017-18, have provided pharmacists with more opportunities to work with other healthcare professionals to improve the patient experience and improve the safe and effective dispensing and use of medicines. Negotiations on the 2019-20 contractual changes will be finalised by February 2019.	
Recommendation 8. The Committee recommends that the Welsh Government investigates ways of harnessing the academic expertise in Wales to understand the scale of Medicine Related Admissions	In January 2018, the Chief Pharmaceutical Officer established a short life working group (SLWG) comprised of medicines safety experts from across Wales to advise on the overall approach and programme required to drive improvements in medicines safety in the NHS in Wales.	A draft report has been prepared by the Short life working group (SLWG) which describes the components of a medicines safety programme for Wales, this is currently being considered by group members. The	Ongoing – to be completed March 2019

Recommendation	Welsh Government response	Update	Completed/ Ongoing
and how to reduce them. **Accept**	The SLWG, which brings together experts both from practice and academia, met in January and March and further meetings are planned for 2018. The SLWG is currently examining sources of data, including but not limited to admissions to hospital, to determine an appropriate suite of measures of medicines related harm as the focus for a programme of work to improve medicines safety in Wales. We recognise significant harm results from medicines related admissions (MRAs) but are concerned that a focus on *post hoc* quantification of MRAs would detract from actions to stop harm before it occurs. The identification of MRAs is made difficult by the presence of confounding factors in many cases, and robust assessments of the prevalence of MRAs have been limited to research studies. There is however, a good understanding of the medicines and situations most frequently associated with MRAs; the priority for reducing medicines related harm will be to address these. The SLWG will conclude its work by	programme recommended by the SLWG requires agreement to support various elements of the programme from a range of stakeholders including 1000 Lives Improvement, Health Education and Improvement Wales (HEIW), the NHS Wales Informatics Service (NWIS) and the Welsh Analytical Prescribing Support Unit (WAPSU). Discussions are planned for early 2019 with the 1000 Lives Improvement Service to agree how they will coordinate the programme starting in Spring 2019 as part of its support for the six priority areas for quality improvement set out in a Healthier Wales. Work has also been undertaken with NWIS and WAPSU to define a series of medicines safety measures and develop a reporting tool which against	

Recommendation	Welsh Government response	Update	Completed/ Ongoing
	October 2018 after which it will perform the role of steering committee for the national medicines safety Programme.	which progress can be measured. The reporting tool will be completed by the end of 2018-19 in readiness for the start of the programme.	
Recommendation 10. The Committee recommends that the Welsh Government co-ordinates a piece of work to share best practice from Health Boards relating to automated vending to help inform future decisions on medicine storage approaches. **Accept**	A workshop on automated ward vending arranged by the NHS Chief Pharmacists peer group, took place in November 2017 and involved a wide range of stakeholders from across all NHS bodies in Wales. The workshop allowed participants to share the experience of implementing automated ward vending in Welsh hospitals and to discuss future approaches to utilizing ward automated medicines storage. An initial report of the workshop has been produced and will be shared with the Committee as part of the comprehensive update on progress against the recommendations made by the Auditor General for Wales, in May 2018. Further work is now being undertaken to agree a set of principles for the further roll out of automated medicines storage. It is envisaged this work will be completed by October 2018.	Report on NHS Chief Pharmacists peer group automated ward vending workshop provided to Committee May 2018.	Completed

Recommendation	Welsh Government response	Update	Completed/ Ongoing
Recommendation 11. The Committee recommends that the Welsh Government identifies whether any lessons could be learnt from NHS England relating to guidance on items which should not be usually be prescribed and the potential savings this approach may deliver. **Accept**	The Welsh Government has reservations regarding the approach being taken by NHS England to restrict the prescribing of some medicines on the basis they are available to purchase 'over the counter' from pharmacies. Such measures have the potential to limit access to effective treatment particularly amongst people on low incomes, and therefore to widen inequalities. The Committee will wish to note the final guidance on this matter from NHS England, included a number of exemptions to allow GPs to continue to prescribe these medicines in specified situations. We encourage NHS bodies in Wales to take measures to reduce unwarranted variation in prescribing and to restrict the prescribing of medicines of limited clinical value. In June 2017, the Chief Medical and Chief Pharmaceutical Officers wrote to NHS Medical Directors requiring health boards to identify all GP practices in their area and any clinical area within secondary care, where co-proxamol was being prescribed, and to instigate the	The All Wales Medicines Strategy Group (AWMSG) has developed guidance identifying a number of treatments that represent poor value for money, or are ineffective or dangerous (published October 2017). This guidance is being implemented by health boards. Follow up guidance which identifies further medicines/ medicines groups is currently being consulted on. Further guidance is being developed which has a focus on the prescribing of over the counter medicines.	Completed Further guidance will be consulted on and provided as required.

Recommendation	Welsh Government response	Update	Completed/ Ongoing
	urgent review of patients with the intention of switching them to alternative, safer treatments. Subsequently in October 2017, the AWMSG issued guidance supporting restrictions to the prescribing of a further four medicines, with a combined annual expenditure of £5.4million in 2016-17) identified as low priority for funding in NHS Wales. Progress to reduce expenditure on these medicines will be tracked by the NHS Chief Pharmacists' Peer Group and reported to the Welsh Government's Efficiency, Healthcare Value and Improvement Group. During 2018-19 the AWMSG will work with the NHS bodies in Wales to identify further opportunities to reduce expenditure on medicines of limited clinical value. The NHS England guidance will be considered in this work.		
Recommendation 12. The Committee recommends that the Welsh Government produces a report on best practice on repeat prescription ordering by	The work of the prudent prescribing implementation group (PPIG) was instrumental in identifying areas where repeat prescribing systems could be improved. Subsequent to Welsh Government officials giving evidence to	The AWTTC has undertaken some initial work collating evidence of the outcomes of various initiatives being undertaken in Wales to improve repeat prescribing,	Ongoing

Recommendation	Welsh Government response	Update	Completed/ Ongoing
cluster groups within the care home settings to help inform policies and actions on repeat prescriptions. And **Recommendation 13.** The Committee recommends that the Welsh Government provides an update on the work of the prudent prescribing group in relation to its work on the various models for repeat prescribing systems in September 2018 to allow the Committee to monitor progress on this. **Accept**	the Committee in March 2016, the PPIG was stood down and responsibility for implementing the recommendations of the group and testing the various approaches recommended to improve repeat prescribing and reduce waste passed to the NHS Chief Pharmacists' peer group. The Welsh Government will collate, from each health board and Community Pharmacy Wales, evidence of the outcomes of various pieces of work being taken forward to improve repeat prescribing, including work to improve repeat prescription ordering within care homes, and provide the committee with an update on this work in January 2019.	including work within care homes. The AWTTC is engaging with health boards and Community Pharmacy Wales to identify suitable examples for inclusion. This work will be concluded by June 2019. On 24th January the Welsh Government and NWIS are also hosting a roundtable of stakeholders to consider issues around prescribing in primary care.	
Recommendation 14. The Committee recommends that the Welsh Government evaluates the roll out of Medicines Transcribing and e-Discharge system to consider the progress and the benefits of this approach. **Accept**	There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines are a significant problem. Improving the transfer of information about medicines across all care settings reduces incidents of avoidable harm to patients, improves patient safety and contributes to a reduction in avoidable medicines related	The uptake and evaluation of MTeD across NHS Wales is being monitored as part of routine progress reports. MTeD has been implemented across the majority of LHBs; the remaining LHBs operate existing medicines discharge systems but are working toward MTeD	Ongoing

Recommendation	Welsh Government response	Update	Completed/ Ongoing
	admissions and readmissions to hospital. Evaluations of the benefits of the Medicines Transcribing and e-Discharge (MTeD) system have been undertaken previously by NWIS[1] and by Cwm Taf University Health Board[2] which demonstrate improvements in the quality and timeliness of discharge information being shared with patients' GPs. During the course of the Committee's inquiry the availability of MTeD across NHS bodies in Wales has increased significantly with MTeD implemented in five and pre-existing e-discharge solutions in place in two health boards. Further enhancements to the MTeD system are planned which will then facilitate its implementation in the two remaining health boards starting later in 2018-19. We expect NWIS and health boards to have appropriate evaluation arrangements in place which ensure the anticipated benefits of the MTeD system are being realised. We will work with NWIS to ensure these evaluation	implementation.	

[1] NHS Wales Informatics Service. Medicines Transcribing & e-Discharge Project Evaluation Report. January 2014
[2] Davies C. e-Discharge Advice Letter Project – End Project Report. Cwm Taf University Health Board, November 2017.

Recommendation	Welsh Government response	Update	Completed/ Ongoing
	measures form part of routine progress reports in relation to MTeD roll out.		
Recommendation 16. The Committee recommends that as part of the Welsh Government's commissioning and roll out of a new e-prescribing system, it develops a supporting plan of action to help achieve the cultural shift that needs to accompany the introduction of a new system. And **Recommendation 17.** The Committee recommends that the Welsh Government shares its action plan and key milestones for the Electronic Prescribing and Medicines Administration (EPMA) system with the Committee. **Accept**	NWIS has established the Welsh Hospital Electronic Prescribing, Pharmacy and Medicines Administration (WHEPPMA) project to develop and implement the national plan for electronic prescribing in secondary care. The project team is currently working with stakeholders to complete the business case for procurement of a replacement hospital pharmacy system and an electronic prescribing and medicines administration solution. The business case will be considered by the Welsh Government in due course. Subject to the completion of a satisfactory business case, it is expected that the procurement of these systems will be initiated during 2018-19 with implementation beginning in 2019. The action plan, including the actions required by NHS bodies to deliver the necessary business change to maximise the benefits of e-prescribing, and key milestones will be established by NWIS through the WHEPPMA project and subject to approval of the business	Outline Business case for the WHEPPA project was approved by the then Cabinet Secretary in December 2018. Development of the Final Business Case is underway and is expected to be submitted by September 2019. e-Prescribing Outline Business Case is being developed by WHEPPMA and is expected to be submitted by September 2019	Ongoing

Recommendation	Welsh Government response	Update	Completed/ Ongoing
	case, we will ask NWIS to share their plans with the Committee.		

Agenda Item 3

Document is Restricted

North Wales Community Health Council – Comments on the Public Accounts Committee report "Wider issues emanating from the governance review of Betsi Cadwaladr University Health Board - February 2016"

Recommendations 1 & 2 – Member Attendance	Performance of Independent Board Members is not an issue that NW CHC is responsible for but we do not believe member attendance to be an issue at this time. In more general terms, the 2017 HIW/WAO Report suggests that the Board had improved and was acting more effectively but still had room for improvement The Deloittes Report, although heavily redacted for the public, has this to say; • *"In our view, executive level leadership capability and capacity needs to be enhanced. It will also require a "strengthening of financial and strategic capability amongst independent members".* • *"Financial and Strategic Planning at the Health Board is simplistic with budgets generally rolled forward into next year."* • *"There is a distinct lack of secondary questioning from Board members to facilitate detailed debate and discussion across the key areas of risk".* • *"The Finance and Performance Committee is spread too thinly, its role is poorly defined and misunderstood by Board members".* There has been a consistent criticism that Independent Board members saw their role as "*supporters*" of the Executive Management Team rather than holding them to account. Until the appointment of the new Chair in the Autumn of 2018 we would have concurred with that view. We now believe this to be changing. The new Chair, Mark Polin, attended CHC Full Council on 22nd January and confirmed that he has now taken over as the Chair of the Finance & Performance Committee.
Recommendation 3 – Sharing of Good Practice	This is not an issue that local CHCs would monitor. It may be better answered by the Board of CHCs in Wales.
Recommendation 4 – Boards routinely with WG share all work commissioned as a result	This would be difficult for a local CHC to monitor. We do have concerns that such work is not routinely shared at local level and this is supported by paragraphs 1.28, 1.29 and 1.30 of the Executive Summary of the 2018 Ockenden Report (*see attached*).

of serious concerns	
Recommendation 5 – WG to implement a systematic approach that ensures that concerns/complaints are adequately dealt with at health board level, and if not, are escalated to the Welsh Government	This is a matter for BCUHB and WG. The Ockenden Report is strongly critical of the BCUHB Board role in complaints/concerns. There have been claims that the poor performance in relation to concerns/complaints has been resolved. We do not recognise any substantial improvement since 2016 in relation to complex concerns/complaints. The performance improvement in relation to 30 day targets seems to have been achieved on a technical basis by sending "holding" letters. We attach two emails from members of the CHC advocacy team which graphically set out the difficulties they encounter on a day to day basis.
Recommendation 13. - GP Out of Hours coverage is unacceptable in Betsi Cadwaladr UHB	GP Out of Hours coverage remains highly problematical and fragile in North Wales. This is, to a considerable extent, a product of the difficulty in recruiting GPs in all settings. The CHC believes that allowing GPs currently on the English Performers List to work in Wales would be particularly helpful in respect of OOH – mainly because it appeals to GPs who want a "portfolio" career. The CHC recommended this strongly in the WG consultation on the Performer List (see attached) but WG has not yet released the outcome of the consultation (*was due Autumn 2018*).
Recommendation 14 - All health boards undertake comprehensive reviews of primary care estate	NW CHC shares this view – our visiting programme looks at the patient experience of primary care estate and confirms the need for an improvement programme. There have been three new Primary Health Care Resources centres opened since 2016 (*Flint, Llangollen and Ffestiniog*). These are excellent additions but they do highlight the poor condition of other settings. At our Full Council meeting on 22nd January, we were advised by Mark Polin that a new Estates Strategy would be up for approval at the next Board meeting
Recommendations 17, 18 & 19	NW CHC commends the work of HIW in North Wales
Recommendation 20 – sharing of complaints data	NW CHC regularly shares anonymised complaints data with its HIW Local Relationship Manager
Recommendation 22 – HIW improve joint working with partner agencies	HIW and CHCs have developed further their joint working arrangements. There is a further All Wales review meeting between HIW and CHCs on 5th February. In North Wales joint working is close and regular. NW CHC visiting teams will often undertake visits at very short notice in order to provide "*on the ground*" information to HIW partners.

Public Accounts Committee

PAC(5)-03-19 : 4 February 2019

Inquiry into Governance Review of Betsi Cadwaladr University Health Board: Lessons Learnt

Briefing Pack from North Wales Community Health Council

Document	Comment
HIW Inspection Report – Hergest Unit – January 2016	This report outlines ligature risks present at that time. The 2014 report had found the same risks previously and set out an action plan which was formally agreed with BCUHB. The 2016 report notes the lack of progress despite assurances that the action plan had been implemented. The ligature risks across the Mental Health Estate were not finally addressed until late 2018. Failure to act on HIIW notices of immediate improvement has been, sadly, a regular occurrence.
Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning - Executive Summary of the HASCAS report – comments on Governance Arrangements	"*4.4 Nevertheless it was also identified that, on occasions, the experience of some patients and their families was compromised due to a combination of systemic failures exacerbated by significant financial restrictions, poor service design and ineffective governance arrangements."*
Lack of Progress under Special Measures – CHC letter of 19th March 2018 to Cabinet Secretary. Also CabSec response of 13th April 2018	This letter sets out North Wales CHCs concerns about the failure of BCUHB to progress under Special Measures. Almost all of these concerns are still extant. We believe the new Chair to be performance focused and determined to resolve the internal issues. The response of the Cabinet Secretary is also attached.
Complaints and Concerns Handling – two email memos from NW CHC advocates are attached.	These emails outline the day to day experience of our Advocacy Team and the difficulties they face in getting appropriate and timely responses. BCUHB have recently made some claims about vastly improved performance in relation to the 30 day response target. We do not recognise this and believe it is being achieved primarily by sending out "holding" letters explaining why the matter will take longer than 30 days. There are further comments on BCUHB complaints handling below under the commentary to the Ockenden Report.

Ockenden Report - 2018 Full report: http://www.donnaockenden.com/downloads/news/2018/07/Donna_Ockenden_Full_Report_2018.pdf (543 Pages) Executive Summary: http://www.donnaockenden.com/downloads/news/2018/07/Tawelfan_Executive_Summary_English.pdf (53 pages)	**Complaints Handling - Page 32** "Throughout 2017 service users were still requiring considerable support from their Assembly Members (AM's) and North Wales Community Health Council (NWCHC) to resolve complaints with BCUHB and the Ockenden team has seen extensive evidence of the support provided by NWCHC and AMs respectively. (For reasons of confidentiality these documents have either been provided directly from the service user/service user representative or with the consent of the service user/service user representative for information to be shared.)" **"***Overall there was deep dissatisfaction and unhappiness amongst those attending the events about the 'concerns' and complaints system at BCUHB both overall and specific to older person's mental health care.***"** This section of the Ockenden Report shows that 3 to 4 years on from the closure of Tawel Fan, the problems of mental health care in North Wales were still not being addressed effectively. --- **16.26 North Wales Community Health Council (NWCHC) visits to Bryn Hesketh in 2016-17** There were three unannounced visits by the North Wales Community Health Council (NWCHC) to Bryn Hesketh in 2016/17. These took place on: • 18th October 2016 • 10th February 2017 • 8th May 2017 The NWCHC visits to Bryn Hesketh in October 2016 was to 'review the beds and staffing levels [and] to look at amenities and fabric of the unit.' (NWCHC 2016, page 1) The visit in February 2017 was a follow up visit to the October 2016 visit. The visit in May 2017 was described as a follow up visit to review actions undertaken following the previous visits in February 2017 and October 2016 (NWCHC 2017 page 1.)

	The latest NWCHC report in May 2017 says of Bryn Hesketh: 'The hospital staffing levels are now in a desperate state.' (NWCHC page 1.) The report states that of the six Band 5 vacancies in the unit, (a further deterioration of two since October 2016) three vacancies were described as 'filled.' These were student nurses who were not registering until September 2017, four months later. Of four Band 6 staff, only one was available for work at the time of the May 2017 NWCHC visit. The unit was staffed by a number of bank and agency staff. Not all of these staff had received appropriate training in 'Restrictive Physical Intervention.' (NWCHC page 2.) This had been raised at the NWCHC visits of October 2016 and February 2017. The report states that there is no doctor available at night in Bryn Hesketh, the unit 'depends on the duty doctor in the Ablett unit being available.' The report notes that one patient from the local area was receiving care in Bradford. (NWCHC 2017, page 2.) Out of area care and treatment was a concern from service user representatives in the 'Listening and Engagement' events held by the Ockenden review throughout the spring and summer of 2017. The report describes that Bryn Hesketh unit 'had been refurbished to a high standard' and that the open spaces were 'delightful.' The NWCHC team were 'delighted to see it being used by patients making full use of the safe area.' (NWCHC 2017, page 3.) **20.3 Working with the North Wales Community Health Council (NWCHC) to facilitate the events:** The Donna Ockenden governance review team worked with the North Wales Community Health Council ('NWCHC') in facilitating these events. The North Wales Community Health Council ('NWCHC') is the independent health services 'watchdog' for North Wales. Its role is to represent the interests of patients and the public who use the health services across North Wales. This role is of great importance given that every person is likely to experience the health service at some time in their lives, to varying degrees and in different ways. NWCHC also plays a role in influencing the way that health services are planned and delivered, in order to ensure the best possible health and wellbeing outcomes for the people of North Wales. The Ockenden review team considered that NWCHC's strength lay in both its statutory status

	and in its ability to represent the interest of patients and the public. In considering the best way to facilitate effective user engagement and listening events across the six counties of North Wales the Ockenden governance review team considered the NWCHC to be an effective and long established link between BCUHB (as those who plan and deliver health services) and the public Independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health as end users and recipients of that health care. NWCHC has a vision statement which simply says 'NWCHC will work to develop health services which are influenced by the views and involvement of the patients and the public of North Wales' (NWCHC 2017).
HASCAS independent investigation and Ockenden governance review: progress report	This BCUHB document sets out progress against the improvement areas set out in the HASCAS and Ockenden Reports. This is a programme that they undertook to complete by May 2019. Progress to date is disappointing and seems to be limited to the creation of policy – rather than the fundamental change of culture and practice called for by the Tawel Fan reports.
Breach of PTR Procedures – On the Spot resolution	Correspondence relating to the use of "On the Spot" resolution. CHC were/are concerned that this ad hoc local procedure removes complainants rights under PTR and prevents them referring their concerns to the Public Service Ombudsman for Wales
Plaudit from Tawel Fan Families	See attached an unsolicited plaudit

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Mental Health/ Learning Disability Inspection (Unannounced)

Ysbyty Gwynedd: Hergest Unit: Betsi Cadwaladr UHB

6 - 8 January 2016

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1. Introduction

Our mental health and learning disability inspections cover both independent hospitals and mental health services provided by the National Health Service (NHS). Inspection visits are a key aspect of our assessment of the quality and safety of mental health and learning disability services in Wales.

During our visits Healthcare Inspectorate Wales (HIW) ensures that the interests of the patients are monitored and settings fulfil their responsibilities by:

- Monitoring the compliance with the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards
- Complying, as applicable, with the Welsh Government's National Minimum Standards in line with the requirements of the Care Standards Act 2000 and the Independent Health Care (Wales) Regulations 2011.

The focus of HIW's mental health and learning disability inspections is to ensure that individuals accessing such services are:

- Safe
- Cared for in a therapeutic, homely environment
- In receipt of appropriate care and treatment from staff who are appropriately trained
- Encouraged to input into their care and treatment plan
- Supported to be as independent as possible
- Allowed and encouraged to make choices
- Given access to a range of activities that encourage them to reach their full potential
- Able to access independent advocates and are supported to raise concerns and complaints
- Supported to maintain relationships with family and friends where they wish to do so.

2. Methodology

The inspection model HIW uses to deliver the mental health and learning disability inspections includes:

- Comprehensive interviews and discussions with patients, relatives, advocates and a cross section of staff, including the responsible clinician, occupational therapists, psychologists, educationalists and nursing staff
- Interviews with senior staff including board members where possible
- Examination of care documentation including the multi–disciplinary team documentation
- Scrutiny of key policies and procedures
- Observation of the environment
- Scrutiny of the conditions of registration for the independent sector
- Examination of staff files including training records
- Scrutiny of recreational and social activities
- Scrutiny of the documentation for patients detained under the Mental Health Act 1983
- Consideration of the implementation of the Welsh Measure (2010)[1]
- Examination of restraint, complaints, concerns and Protection of Vulnerable Adults referral records
- An overview of the storage, administration, ordering and recording of drugs including controlled drugs
- Consideration of the quality of food
- Implementation of Deprivation of Liberty Safeguards (DOLS).

[1] The Measure is primary legislation made by the National Assembly for Wales; amongst other matters it makes provision in relation to assessment, care planning and coordination within secondary mental health services.

3. Context and description of service

Healthcare Inspectorate Wales (HIW) undertook an unannounced visit to the Hergest Unit on the evening of 6 January and all day on the 7 and 8 January 2016. We inspected all three wards, Aneurin, Cynan and Taliesin the Psychiatric Intensive Care Unit (PICU)[2]

The Hergest Unit is a specialised mental health hospital situated within the grounds of Ysbyty Gwynedd Hospital run by Betsi Cadwaladr University Health Board (BCUHB) and provides a comprehensive range of acute mental health services including psychiatric intensive care services (PICU).

Aneurin and Cynan are both acute wards, each having 16 beds. Aneurin accommodates female patients and Cynan ward male patients. Taliesin is a six bedded PICU.

During our inspection we reviewed patient records, interviewed patients and staff, reviewed the environment of care and observed staff-patient interactions. HIW's review team comprised of one peer reviewer, one lay reviewer and two members of HIW staff.

[2] A psychiatric intensive care unit (PICU) provides care and treatment for people experiencing the most acute phase of a mental illness. A PICU is a safe, secure and low stimulus ward environment.

4. Summary

Our January 2016 visit to the Hergest Unit at Ysbyty Gwynedd was a follow-up visit, focusing primarily on the issues that HIW identified in May 2014. It was pleasing to note that considerable improvements had been made to address some of the matters we identified in our previous visit as well as other improvements. These included:

- the intensive care suite (ICS) had been modified with a separate en-suite facility which provided improved privacy and dignity for patients using this facility.
- Patient information displayed on whiteboards in the nurses' office was covered up when not in use. This improvement enabled patient information to be visually protected from visitors and other patients.
- Mandatory training for staff had improved considerably with higher compliance rates across all wards. We did however identify some areas in which improvement needed to be made and this is listed under the Training section of the report.
- A system was in place for staff to receive regular and documented supervision, with the majority of staff confirming that this takes place on an on-going basis.
- The achievement of AIMS[3] in 2015 reflects improvements made at the Unit.
- Staff morale had improved and was generally good across all wards, however, some frustrations were identified which the health board need to consider and act upon (see Governance section)

[3] AIMS - Accreditation for Inpatient Mental Health Services. AIMS is a standards-based accreditation programme designed to improve the quality of care in inpatient mental health wards. Accreditation assures staff, service users and carers, commissioners and regulators of the quality of the service being provided. www.rcpsych.ac.uk/AIMS

- Advocacy services were spoken highly of by both patients and staff and the independent patient forum was a very positive initiative
- Patients and staff spoke favourably of the food served at the unit in relation to the quality, choice and portions of food served.

In addition to the improvements noted, we also identified good practices which we have continued to observe during our visits to the unit. These were specifically the receptive way staff engaged with the inspection programme and the number of positive staff and patient interactions we observed throughout our visit.

Despite the good practice identified, we also found significant scope for improvement in a number of areas. Following our visit we issued an immediate assurance letter to the health board regarding concerns that could potentially pose a risk to the safety of patients. The purpose of this letter was to seek assurance from the health board of the actions they have and will undertake to mitigate the risks. The areas we have identified for improvement are documented in Appendix A, but a summary of the main issues include:

- A considerable pressure on in-patient beds with the number of patients exceeding the 16 available beds, on both Aneurin and Cynan wards. Frequently a 17th and 18th bed are provided on the wards to accommodate additional patients. Existing patients could also be moved around the wards. This situation is very unsettling for patients and creates difficulties for staff.
- Issues regarding staffing were identified, specifically on Aneurin ward. We identified that on a number of occasions there was only one registered nurse on the ward and sometimes they were the 'bleep'[4] holder for the whole unit. A significant number of occasions were identified when staff had not been taking breaks due to the demanding workload and nature of the ward. Some staff had accumulated

[4] Bleep holder holds the bleep for communication purposes. The bleep holder will be used to contact members of the team for emergency and urgent calls and respond to Section 136 admissions.

significant time owed to them due to staff shortages and the need to work overtime.

- A number of vacancies across the unit including medical, nursing and support staff
- A ligature risk assessment had identified significant safety issues across the three wards. Numerous ligature risks were identified which included beds, door closures and bathroom pull cords. It was identified that new beds had been ordered in August 2015 and at the time of our visit had not arrived. The outstanding actions from the ligature risk assessments, which are undated need to be addressed and completed as a matter of urgency.
- The admission criteria for the Unit needs to be reviewed to ensure that patients can be cared for appropriately. A number of patients had been recently admitted with a more organic type of illness e.g. dementia and these patients require specific care for their individual needs.
- A number of sets of patient documentation were examined on Aneurin ward and some significant issues were identified in relation to the care and treatment of a patient who had recently fallen.
- Environmental issues were identified that need to be addressed and include water temperatures that were too hot in some areas and too cold in others. Windows that inappropriately screwed shut and could not be opened. In addition the nurse call systems did not meet the guidance documented and initiated by the health board on the Risk of Falls Pathway.

5. Findings

Core Standards

Ward environment

The Hergest unit is a self contained building situated in the grounds of Ysbyty Gwynedd. The unit has its own entrance and reception. The unit is single storey with three operational wards and a number of offices for staff.

On entering the reception area, doors lead to a number of areas and wards, including Taliesin ward, a psychiatric intensive care unit (PICU) and two acute wards Cynan for male patients and Aneurin for female patients.

Taliesin ward is a six bedded PICU for both male and female patients. The ward is locked with access to the ward via a key fob system for staff and an intercom system for visitors. The ward provided six single bedrooms which contained a wardrobe for patients to store personal belongings. Patients on the ward had access to shared gender specific toilet and showering facilities. The observation panels in the bedroom doors could only be operated from the outside.

Taliesin ward had a shared lounge with enough seating for the number of patients the ward can accommodate. A TV was fitted to a wall and there were some books on the window sill. There were two tables in the lounge and some pictures on the wall. Taliesin ward did not have any single gender lounges.

The dining room at the time of our visit had one table and four chairs which was not enough for all patients to eat together, however there were a number of easy chairs in the room.

It was pleasing to note that following our previous visits the intensive care suite (ICS) room had been modified and improvements made to the room that included a separate en-suite facility. A clock was also visible to allow patients to orientate themselves when in this room.

Patients had access to an outdoor area. The garden was contained and used only by patients on Taliesin. The garden had seating and areas of shrubbery which made the garden area more pleasant.

A payphone was situated in an open space which did not provide privacy for anyone using it.

Not all the call bells situated in bedrooms and other patient areas were within easy reach of patients.

The ward environment was adequate for a PICU and provided low stimulus areas that this ward requires.

Aneurin (female) and Cynan (male) wards were environmental duplicates of each other. They both were 16 bedded wards with a mixture of single and dormitory style bedrooms. Each ward had shared bathroom, showering and toilet facilities. We noted that signage on the wards required updating because bathrooms had signs stating male or female areas on them instead of being specific to the gender that the ward was accommodating.

Patients in single bedrooms on Aneurin and Cynan wards could lock their bedroom doors but this could be over ridden by staff if necessary. There were no locks on the dormitory rooms. The observational panels in bedroom doors could only be operated on the outside. Therefore patients were unable to control the observation panel for key day to day activities, such as undressing.

On Aneurin ward we noted that the bathroom had two bars of soap stored on the side of the bath, which was a potential infection control issue. In the shower room a number of products were stored on the radiator, including shampoo, shower gel and air freshener. The items were not appropriate to be left in the room due to the harm they may cause an unattended patient, especially if the bathroom door was not locked. The flooring in the shower room had burn marks from a recent incident and needs to be cleaned or replaced.

At the time of our visit the water temperature in the bath on Aneurin ward was very hot and in the bathroom on Cynan ward the water was running cold. No temperatures were being regularly recorded by staff to ensure an appropriate water temperature was available. At the time of our visit, we requested evidence that these temperatures were being recorded on a regular basis but documentation was not provided.

Throughout all the wards staff told us that some windows would flap open and bang if the weather was windy. This was due in part to the lack of closures on the windows and to overcome this on some wards that windows were screwed shut. In a dormitory on Aneurin ward all three windows were screwed shut and could not be opened to allow air to circulate. In addition, the windows that could be opened on the wards had potential ligature risks.

We identified a number of nurse call bells in rooms including bathrooms and bedrooms that were not conveniently located. In a number of bathrooms, the call bell was situated opposite the toilet. Therefore if a patient required assistance then they would have difficulty accessing the nurse call system. In addition, dormitory bays had one nurse call system for three or four patients. A review of patient access to call bells is required because it is in direct contradiction to the instruction written on the ‘Risk of Falls Pathway’

document, which clearly states call bells must be in sight and reach of patients at all times.

We identified a number of ligature risks throughout all the wards, especially beds, door closures and bathroom pull cords. This needs to be addressed in accordance with the ligature risk assessments, which are undated that was undertaken.

Aneurin and Cynan wards had pictures displayed on the walls of the corridors and both wards had notice boards displaying a good range of information and leaflets in both Welsh and English.

The lounges on both wards provided easy chairs, TVs and tables. At the time of our visit, the lounge on Aneurin ward was being utilised by a number of patients who were knitting and one patient reading. There was a puzzle on the table that had been started by a patient and there were book shelves with games and books available.

Both wards had their own garden areas which were small but landscaped.

A section 136 suite was available at the Hergest unit, which provided adequate facilities for persons using the suite.

Recommendations

Water temperatures across all wards need to be checked and regularly monitored to ensure a safe and consistent temperature is maintained. This was of particular concern in the bath on Aneurin ward.

All windows across the unit need to be reviewed, specifically windows in patient bedrooms and areas to ensure they can be operated appropriately and do not present a ligature risk.

Signage across all wards needs to be updated to ensure it is appropriate to the patient group.

Patient access to call bells needs to be reviewed because it was in direct contradiction to the Falls Pathway documentation and in one dormitory there was only one call bell for up to four patients.

A review of all the required actions from the ligature risk assessments need to be undertaken as a matter of urgency.

Safety

Discussions with patients highlighted that the majority with whom we spoke said they felt safe at the Hergest Unit. Two patients who said they didn't feel safe gave examples of other patients having the potential to be violent and concerns about who could enter the dormitory bedroom because they were unable to lock the door. The majority of staff we spoke to did not identify any safety issues, however some did mention potential ligature risks in bathrooms and with beds. Staff had mitigated these risks by locking the bathroom door so patients have to request to use it, however the door on Aneurin bathroom was not locked on the evening of our inspection.

We identified issues around staffing, specifically on Aneurin ward. There had been a number of occasions when one registered nurse was on the ward and had also been the bleep holder. Therefore if they were dealing with the bleep call their ward would have been left without a nurse or would have had to borrow another registered nurse from a different ward. We also identified a significant number of occasions when staff were not taking breaks and as a result some staff had accrued a significant amount of time owing. These areas need to be reviewed to ensure patient and staff safety.

Over occupancy of beds was clearly an issue on Aneurin and Cynan wards. Frequently additional beds were put on the wards to accommodate additional patients. At the time of our visit, Aneurin ward was over capacity. There was one patient in the general hospital receiving care and treatment for a fractured hip. Their bed had been allocated to a new admission and if the patient was to return to the ward an additional bed would be required.

In addition to the above, there had been a number of occasions when the bronze on call had told staff at the Hergest to put up additional beds for new admissions. This situation has resulted in inappropriate admissions being made, with a male patient being admitted to a female ward. Staff on call were not always aware of the service provided by the Hergest unit and this needs to be reviewed and changed to ensure on call staff have knowledge of the service and where necessary gain specific advice from nursing staff at the unit to ensure admissions were appropriate.

A number of potential ligature risks were identified throughout the wards specifically beds, door closures and pull cords in bathrooms. It was pleasing to note that new beds had been ordered in August 2015, however, at the time of our visit they had not been delivered. Staff had also put measures in place to mitigate risks in patient bathrooms. All areas need to be reviewed and actioned in accordance with the ligature risk assessments.

We noted during our night visit that not all staff were wearing personal alarms on Aneurin and Cynan wards, despite the allocation of alarms to visitors. It is

important that staff safety is reviewed and personal alarms are worn by staff at all times.

The information contained on the patient board on Aneurin ward was difficult to understand. The board at the time of our visit appeared to list 20 patients when there were not 20 patients on the ward. After some scrutiny we concluded that three patients listed were not currently on the ward. One patient was on Taliesin, one patient was an inpatient in the general hospital and other was on long term community leave. Some improvements to the notice board should be made to avoid any confusion in relation to actual patient numbers.

Concerns about the patient mix was raised by some staff, stating that some patients are being admitted that staff feel were unsuitable for the unit. Not only has this resulted in some incidents, there were concerns that facilities were not available or suitable especially for patients with dementia. Some members of staff also felt they might not have the necessary knowledge and experience to nurse dementia patients.

Recommendations

The staffing issues identified need to be addressed, specifically to ensure staff take breaks and time accrued is effectively monitored and managed. The allocation of the beep needs to be reviewed to ensure no wards are left without a registered nurse.

The over occupancy of beds must be addressed as a matter of urgency.

Staff assigned to the bronze on call system need to have improved knowledge of the Hergest unit to ensure their decisions are appropriate so that staff and patient safety is not compromised because of those decisions.

A review of usage of personal alarms is required to ensure staff are allocated and use alarms when on duty.

The multi-disciplinary team

The staff we spoke to felt their team worked in a professional and collaborative way and attended regular case reviews for their patients.

Multi disciplinary team meetings (MDT) are attended by the disciplines that have been involved with that particular patients care. Staff told us that psychology were more accessible because they were based at the unit and therefore could see patients quickly. MDT meetings take place on a regular basis, however some staff did state that community teams/key workers find it difficult to attend meetings.

Some members of staff felt that their views/opinions were not valued by some members of the clinical team. All members of staff must feel valued and professional views respected by all members of the clinical team.

The number of consultants for some wards were as many as seven which meant a lot of wards rounds and pressure on nursing staff. Staff told us that they had a ward round timetable to accommodate the number of consultants for their ward, but some consultants could turn up unannounced, again putting additional pressure on nursing staff.

Staff said they regularly attended staff meetings however at the time of our visit no minutes were available for Aneurin ward. Some minutes of meetings were presented after our feedback session. It is essential that regular team meetings take place and minutes capture the discussions and outcomes to enable all staff to be aware of them. Staff had handover meetings between each shift.

Recommendations

All members of the MDT must feel part of the team and that their opinions are valued and respected within the MDT.

Privacy and dignity

Some patients had single bedrooms and other patients were in three or four bedded dormitories. Discussions with patients and staff did confirm that everyone would prefer single occupancy bedrooms. In the dormitories curtains are used to separate individual beds, however curtains do not provide privacy for patients to discuss personal matters with staff and patients complained of being disturbed by other patients.

A lack of space on the wards was commented on by both patients and staff. Patients told us that there were limited places to meet with family and friends on the wards and staff said there was not enough space for one-to-one meetings with patients.

The majority of patients we spoke to said they were shown around the ward when admitted and 50% of patients we spoke to could confirm they had a named nurse.

The patients we spoke to told us that staff respected their privacy and dignity and would knock on bedroom doors before entering. Observation panels in bedroom doors were operational from the outside only, therefore patients could not alter the panel from inside their bedrooms in order to obtain privacy.

Patients had access to phones to maintain contact with family and friends. Some patients had their own mobile phones, while others had access to a ward payphone. At the time of our visit, there was one broken telephone on Aneurin ward. The other telephone could only receive incoming calls. The payphone on Taliesin ward was situated in the corridor and did not provide any privacy for the person using it. Staff told us that patients could use the office phone if they requested.

It was pleasing to note that following previous visits, patient information displayed in nursing offices on white boards was covered when not in use, therefore protecting patient information.

Patient therapies and activities

Displayed on wards were activity timetables offering patients a range of activities between Monday and Friday. Facilities at the Hergest unit were wide ranging and included an occupational therapy (OT) kitchen, art and craft room as well as an activity room. The activity room provided patients access to games, books, table tennis, a piano, computers without internet access and a treadmill.

Despite the facilities available, the majority of patients we spoke to told us that they didn't have enough activities to do and only a few patients said they had been asked what they like to do. One patient told us that they found the days long because of limited activities and that the facilities were not being used because patients need to be escorted by staff.

Discussions with staff confirmed that patients can only use the above facilities if staff were available. At the time of our visit, use of the facilities was limited because there were no activity co-ordinators in post.

Occupational therapy staff described their process of assessment, which starts with a referral from the ward or community mental health team. OT staff undertake a baseline assessment using various standardized and non-standardized assessments. The end result is an individual plan for the patient which is documented and saved in their care plan so all staff can follow it.

OT staff told us that they run group and individual sessions for patients which might include cooking, shopping, using transport and home visits. During term time, on two evenings a week, students facilitate activities such as art, table tennis, watching films and music. On weekends, activities which have included trips out to local attractions were arranged and organised by ward based staff.

Patients who do not have Section 17 leave are more restricted in their choice of activities. Informal patients do not have these restrictions.

During our night visit we saw a group of patients knitting and crocheting and observed a positive interaction between patients and staff.

There was dedicated psychology input for the unit, however during our visit we were unable to meet with them for specific feedback. Staff confirmed that no weight, diet or smoking cessation programmes were offered to patients.

If patients required access to other services, such as a dentist, optician and/or podiatrist this would be arranged by staff. General physical health screening was carried out by staff.

Posters were visible on the wards advertising advocacy, Citizen Advice Bureau and Hafal services, they included contact details. The majority of patients we spoke to knew how to make a complaint should they need too and also knew how to contact the advocate. All the staff we spoke to told us how good these services were and how regular they attend the unit to support patients. Having external services that can support and help patients with their concerns and are well thought of by patients and staff is noteworthy.

In addition to the above, an independent patient forum run by Unllais undertakes monthly patient meetings. Patients from each ward are invited to attend the meetings to raise any suggestions and/or concerns. Minutes from the meetings are displayed on each ward and ward managers are required to respond to the any actions arising. These independent patient forum meetings are a positive initiative and an example of transparency by the Hergest unit regarding patient care.

Recommendation

The appointment of activity co-ordinators is required to ensure the provision of OT is not negatively impacted upon.

General healthcare

We identified a number of issues regarding the Frailty Project which must be addressed. These included:

- Numbers were in excess of the planned bed availability.
- Patient access to the nurse call alarm system was not available despite the health boards 'Risk of Falls Pathway' document clearly endorsing a call bell in sight and reach of patients at all times.

- Development of a group of specialist staff is required because of the patient mix evident on the wards.
- Training needs to be improved to adequately provide for this patient group.
- Flexible admissions to be considered because some patients under the age of 65 may require the service.

Recommendations

The areas identified regarding the frailty project must be addressed, specifically bed availability provision, specialist staff, staff training and admissions for patients under the age of 65.

Food and nutrition

All the patients and staff we spoke to commented favourably on the food served at the unit. Patients were offered four meals a day, including breakfast, lunch, tea and supper.

Patients were provided with menus to choose their meals from. Their choices included a vegetarian option. In addition, snacks were also available including sandwiches and/or jacket potatoes.

All the patients we spoke to said the food portions were ample and that there was good variety offered. Staff told us that patients with specific dietary needs were catered for and access to dieticians was available.

Any patient requiring a drink or snack outside of the set mealtimes was able to obtain one. Hot and cold drinks were available as was a variety of snack options stored in the ward kitchens. Patients did have the choice to order a take away on Saturdays if they wished.

Patients were weighed regularly as part of their general physical healthcare.

Training

We reviewed 10 staff files and identified some inconsistencies with the employment information contained on file. One file had a checklist which had confirmed all the pre and post employment information had been obtained including job description, application form, two references, interview notes, contract of employment and induction. However none of this information was on file. Other files reviewed had emergency contact details and certificates of

fitness while other files did not have this information. A standard approach needs to be applied across all staff files to ensure consistent employment processes.

It was pleasing to note that systems were in place to ensure that professional registrations were up to date. Ward managers check websites to ensure compliance with registrations and the e-rostering system provides a flag up system to staff when registrations are a few months from renewal.

Following on from previous visits, a much more robust and well documented system of staff supervision was in place. Discussions with staff confirmed that the majority receive regular formal supervision which is documented. A number of informal supervision sessions also take place of which staff spoke positively.

Eight out of 10 staff files reviewed had evidence that they had received a performance appraisal and development review in the last 12 months.

A programme of mandatory training was in place for staff and a system was being used to capture, record and monitor progress for each employee. An analysis of training statistics across the three wards did highlight significant improvement in compliance rates. There were a number of areas that need improvement and these need to be monitored to improve compliance. Such areas included equality training which was under 30% compliance on Taliesin and Aneurin wards. In addition health and safety training which was under 30% on Aneurin and Cynan and 10% on Taliesin ward.

There were some vacancies across the unit that need to be filled to ensure a full complement of staff. We identified a lack of activity co-ordinators across the unit and this was having a negative impact upon OT provision because their resources were being spread thinly. The recruitment of a ward clerk is required because at the time of our visit one ward clerk was being shared between all three wards. In addition, a high number of responsible clinician (RC) vacancies were still outstanding. Locum RC's were filling vacancies on a temporary basis. A review of staffing is required to ensure a full complement of staffing can be filled for the unit.

Staff told us morale was better across the whole unit, however some staff spoke of their frustration when issues take a long time to resolve. Staff dynamics were also cited as affecting morale.

We were told by staff that there was a lack of debriefing/lessons learnt sessions for staff following patient incidents and incident reports were not available following an incident. It is essential that this area is reviewed and staff attend a debriefing/lessons learnt session to ensure good practices are continually delivered and risks mitigated as much as possible.

Since our previous visit in May 2014 the Hergest unit has promoted initiatives to develop staff. Therefore it was pleasing to note that the unit had achieved AIMS.

Recommendations

A standard approach needs to be applied to all staff files to ensure that evidence of all appointments is consistent.

A review of staffing is required and recruitment to some key posts is necessary to ensure wards are operating at full complement.

Staff morale, particularly on Taliesin ward needs improvement, with a specific focus on the time frame to resolve issues and staff dynamics.

Debriefing/lessons learnt must form part of staff communication to ensure good practices are continually re-enforced and risks mitigated as far as possible.

Governance

A high number of responsible clinician (RC) vacancies throughout Betsi Cadwaladr health board continue to be unfilled. During the feedback meeting we were assured that this issue is being addressed. A recruitment strategy is required.

The demand on in-patient beds as described in the ward environment section requires urgent attention. A bed management strategy is required to deal with the issue. In addition, better knowledge and understanding of the service requirements for those staff on bronze on call needs to be addressed to ensure admissions are appropriate.

Delays in obtaining new furniture, including new beds which had been ordered in August 2015 need to be reviewed. The time lapsed is unacceptable and impacts upon ligature issues.

Despite improvements in staff morale throughout the unit there was evidence of low morale on Taliesin. Staff dynamics were cited as key factors. A review of these issues needs to be undertaken.

Recommendation

A review of the governance/audit systems and processes need to take place to ensure the health board has robust and adequate information conveyed to them.

All the areas identified must be addressed, specifically:

- A recruitment strategy to fill the high number of RC vacancies

- A bed management strategy to manage the demand of in-patient beds
- An acceptable time frame for the delivery of new furniture needs to be established
- A review of and strategy to deal with the issues on Taliesin ward regarding staff morale

Monitoring the Mental Health Measure

We reviewed the care and treatment planning documentation for six patients at the Hergest unit and identified the following observations:

- One patient had a risk of falls identified but no care plan was in place to address the risk

- The observation records for one patient who fell were missing and could not be located

- One patients self elected use of a wheelchair was not risk assessed or care planed

- The use of the Mental Health Measure documentation needs to be improved because there was a lack of detail on the files we reviewed. As a consequence further training in the use of the Measure needs to be implemented.

Recommendation

All the areas identified must be addressed, including ensuring all risk assessments are undertaken and in place for patients, observation records are maintained and are accessible. The use of the Mental Health Measure documentation needs to be improved.

Application of the Mental Health Act

We reviewed the statutory detention documents of three of the detained patients being cared for on one of the wards. The following issues were identified:

- Section 17 leave forms were in need of updating as 'to' dates had expired and recording of leave was not easy to follow.
- Section 17 leave was not being evaluated.
- Observational recording sheets did not have dates.
- The files we reviewed had evidence that patients had been read their rights and that an independent Mental Health Advocate (IMHA) had been involved. However there was no evidence on the files or audits in place to confirm that these actions were being repeated.
- The Mental Health Act administrators were not receiving hospital manager reports in time.
- Due to the number of locum doctors, MHA administrators have to continually check that the doctor is an approved clinician and section 12 accredited.

Recommendations

All the areas identified must be addressed, specifically to ensure section 17 leave and observation forms are appropriately completed and evaluated, hospital manager reports to be completed and submitted to the MHA administrators in a timely manner. Patient rights need to be read and evidenced accordingly and systems are required to ensure checks are completed promptly for locum doctors to prove their approved clinician and section 12 status.

6. Next Steps

The health board is required to complete an Improvement Plan (Appendix A) to address the key findings from the inspection and submit its Improvement Plan to HIW within two weeks of the publication of this report.

The health board's Improvement Plan should clearly state when and how the findings identified at the Hergest Unit will be addressed, including timescales.

The health board's Improvement Plan, once agreed, will be published on the Healthcare Inspectorate Wales website and will be evaluated as part of the on-going mental health/learning disability inspection process.

Appendix A

Mental Health/ Learning Disability: **Improvement Plan**
Health Board: **Betsi Cadwaladr University Health Board**
Hospital: **Ysbyty Gwynedd, Hergest Unit**
Date of Inspection: **6th – 8th January 2016**

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
1. Ward Environment				
1.1 Water temperatures across all wards need to be checked and regularly monitored to ensure a safe and consistent temperature is maintained. This was of particular concern in the bath on Aneurin ward.	1.1.1 All baths must be temperature checked using a thermometer before patients enter the water, based on best practice across the Health Board.	1.1.1 Confirmed at Senior Nurses Meeting 11th February 2016 that water temperatures are to be checked using a thermometer on all wards, and any issues should be raised immediately with the Estates Team. All thermostatic devices fitted to water outlets are checked every six months for correct functioning and adjusted accordingly by Operational Estates. Where fitted to a bath, a failsafe test is also carried out to ensure the hot water supply is automatically shut off if the cold water supply fails.	Locality Manager; Matron Estates Operations Manager – West	31st March 2016 31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	1.1.2 Health Board best practice to be identified and clear guidance provided to ward nurses on temperature range.	1.1.2 Locality Manager to discuss with Learning Disability Services Matron and develop guidance.	Locality Manager	31st March 2016
1.2 All windows across the unit need to be reviewed, specifically windows in patient bedrooms and areas to ensure they can be operated appropriately and do not present a ligature risk.	1.2 See 1.5.2	1.2 This matter has been logged on the Risk Register. A detailed external Audit has been commissioned through external Consultants. This work defined the high risk areas which in turn has necessitated the completion of RA for the management of specific clinical areas. This work was completed by the Clinical MH&LD teams. The Anti-Ligature Project Team have procured a BCUHB wide Contractor Framework to undertake the project work which is scheduled to commence on the 1st March 2016.	Locality Manager Head of Capital	To begin 1st March 2016; running until 31st March 2017. Commencing on 1st of March completion by June 2016
1.3 Signage across all wards needs to be updated to ensure it is appropriate to the patient group.	1.3 Signage review is not currently part of the Estates plan for Hergest in 2016-17, as a decision needs to be reached by	An Interim solution to signage will be agreed between local management and estates.	Matron/Locality Manager/Director of Estates	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	the Division regarding the appropriate patient group for the Unit, which will affect any signage used.			
1.4 Patient access to call bells needs to be reviewed because it was in direct contradiction to the Falls Pathway documentation and in one dormitory there was only one call bell for up to four patients.	1.4.1 Patients assessed as being at risk of falls are given personal alarms worn on the wrist. These are in place and being used.	1.4.1 Complete	Matron	29th February 2016
	1.4.2 A wireless nurse call system will be investigated and a proposal sent to the Divisional Leadership Team for consideration.	1.4.2 Operational Estates representatives have met with the Matron to detail areas of shortfall. Costs will be obtained from Static Systems Group to provide suitable extensions to the existing system either hard wired or wireless as appropriate.	Estates Operations Manager – West	31st March 2016
	1.4.3 Floor sensors have also been purchased and were delivered 11/02/2016, to be fitted by end February 2016.	1.4.3Purchased and delivered, to be installed.	Matron	29th February 2016
1.5 A review of all the required actions from the ligature risk assessments need to be undertaken as a matter of urgency.	1.5.1 Purchase of anti-ligature beds.	1.5.1 New anti-ligature beds have now been procured and have been delivered- COMPLETE	Locality Manager	29th February 2016
	1.5.2 Review of required work to complete Anti-Ligature Project and prioritisation of same.	1.5.2 Extensive estates work regarding ligature risks have been reviewed formally in Estates sub-group and work prioritised	Head of Capital	To begin 1st March 2016 completion by June 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
		as per Anti-Ligature Project Plan which commences on 1st March 2016.		
2. Safety				
2.1 The staffing issues identified need to be addressed, specifically to ensure staff take breaks and time accrued is effectively monitored and managed. The allocation of the beep needs to be reviewed to ensure no wards are left without a registered nurse.	2.1.1 Implement a National Mental Health (Inpatient) Ward Acuity Process, and present the results of this to the Divisional Leadership Team to guide decision-making for the Unit.	2.1.1 This commenced in February 2016. Results are expected to be presented to Divisional Leadership Team in March 2016.	Locality Manager; Matron	31st March 2016
	2.1.2 Division to commence a review of the skill mix within the Unit based on results of 2.1.1, with particular regard to numbers of RMNs available in the Unit over the 24hr period.	2.1.2To commence once 2.1.1 complete.	Director of Nursing; Divisional General Manager	30th June 2016
	2.1.3 The Divisional Managers to have a system for closely monitoring e-rostering against the required staffing template. To ensure that e-rostering is fully utilised as a planner and management tool to ensure reliability and cross-cover within the Unit.	2.1.3E-roster use is currently being reviewed by Divisional Leadership Team.	Interim CRES Programme Manager	31st August 2016
	2.1.4 The Senior Nurse / Bleep Holder role to be in addition to establishment ward staffing, not part of it.	2.1.4This is already in place and occurs only in exceptional circumstances where mitigation to manage the situation is put in place.	Locality Manager; Matron	completed

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	2.1.5 Accumulation and use of TOIL to be managed under the current Health Board policy – audits to be undertaken followed by managerial intervention where required.	2.1.5 Matron to provide monthly position statement on TOIL to Divisional General Manager as of April 2016.	Matron; Divisional General Manager	1st April 2016
	2.1.6 Division to review how shifts are managed in practice, and introduce shift workplans across all wards. Effectiveness of shift workplans to be monitored through daily escalation tool and monthly quality audit.	2.1.6 Confirmed at Senior Nurses Meeting 11th February 2016 that shift workplans are to be in use on all wards, and any changes to the workplan due to challenges or pressures should be escalated to the Matron through the Daily Escalation Tool.	Matron	1st April 2016
2.2 The over occupancy of beds must be addressed as a matter of urgency.	2.2.1 The immediate use of the daily escalation support tool will be utilised for any bed which is being required.	In use across all wards; to be reiterated and included in all Senior Nurses Meetings. It was agreed by the Divisional Leadership Team on 15 February 2016 that to ensure the safest environment with appropriate staffing levels in the current accommodation, Hergest will operate 2 x 16 bed wards (plus PICU).	Locality Manager; Matron	1st April 2016 Completed
	2.2.2 Divisional Leadership Team	2.2.2 See above	Divisional	Completed

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	has provided definitive operational guidance regarding the management of finite bed numbers in the Hergest Unit (see above).		Leadership Team	
	2.2.3 The guidance document will set out bed management guidelines to staff and managers with regard to bed pressures and escalation when required.	The Hergest Operational Policy will be reviewed and revised to ensure clarity for admissions, including bed management.	Matron/Locality Manager	31st March 2016
	2.2.4 To manage capacity the Division will develop and maintain region-wide Bed Status Dashboard, accessible to Duty Nurses, Home Treatment Teams, Matrons and On-Call Managers.	2.2.4 Bed Management and Patient Flow is currently being reviewed by Divisional Leadership Team. An existing patient flow system used in acute physical health care will be considered and adapted for use in mental health care.	Interim Programme Consultant	31st August 2016
	2.2.5 Division to prescribe whole system "patient flow" protocols and apply to service, including Continuing Health Care, Delayed Transfer of Care, discharge planning milestones.	See 2.2.4	Interim Programme Consultant	31st August 2016
2.3 Staff assigned to the bronze on call system need to have improved knowledge of the Hergest unit to ensure their decisions are appropriate so that staff and patient safety is not compromised because of those	2.3 Divisional Leadership Team has provided definitive operational guidance regarding the management of finite bed numbers in the Hergest Unit.	See 2.2.2 above.	Matron/Locality Manager/ Divisional General Manager	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
decisions.	The revised Operational Policy document will set out bed management guidelines to staff and managers with regard to bed pressures and escalation when required.			
2.4 A review of usage of personal alarms is required to ensure staff are allocated and use alarms when on duty.	2.4 Personal alarms are available in sufficient numbers for staff and should be in use on wards.	2.4 In use across all wards; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager; Matron	Complete
3. The Multi-Disciplinary Team				
3.1 All members of the MDT must feel part of the team and that their opinions are valued and respected within the MDT.	3.1 Staff engagement exercise to be completed for West Locality to understand specific issues and challenges to good MDT working across all specialities. Implement the use of the NHS Engagement Diagnostic Tool and the NHS Wales staff engagement resource for all leadership roles in West Locality.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016
4. Patient Therapies and Activities				
4.1 The appointment of activity co-ordinators is required to ensure the provision of OT is not negatively impacted upon.	4.1 Two activity co-ordinators have been appointed and are pending employment checks. Expected to start work by April 2016.	4.1 Complete	Matron	1st April 2016
5. General Healthcare				
5.1 The areas identified regarding the frailty project must be addressed, specifically bed availability provision, specialist staff, staff training and	5.1.1 Division to consider development of complex / frail health care either within the existing ward environments or	Linked to 2.2.2 Divisional Leadership Team to explore alternative inpatient	Director of Nursing	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
admissions for patients under the age of 65.	whether a separate ward environment would be more appropriate.	environments able to provide safe, age appropriate care for complex, frail patients.		
	5.1.2 The Division to re-establish use of the falls pathway already introducedto clinical areas. The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.Confirmed at Senior Nurses Meeting 11th February 2016 that falls pathway will be in use across all wards; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager, Matron	Completed
	5.1.3 Division to investigate and procure as appropriate assistive technologies and supplementary equipment with regards to falls prevention, i.e. call systems that are ligature safe and bed sensors / alarms.	See 1.4	Matron	29th February 2016
	5.1.4 Division to commence active monitoring of the levels and complexity of patients currently under its care. To provide assurance that appropriate risk mitigations are in place.	See 2.1.1 Acuity review to be undertaken.	Locality Manager; Matron	31st March 2016
	5.1.5 A review of specialist skills required to support and meet all physical and mental health needs	See 2.1.1 To be based on results of acuity review.	Director of Nursing	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	must be undertaken across all inpatient areas of the Division.			
	5.1.6 Compliance against mandatory training to be reported in Locality Governance Meeting.	5.1.6 Report is sent to Locality Governance Meeting bi-monthly.	Divisional Training and Development Co-ordinator	29th February 2016
	5.1.7 Specialist training needs analysis to be undertaken as highlighted above.	See 5.1.5	Director of Nursing	31st August 2016
	5.1.8 Training in complex / frail health care issues to be delivered and ward "champions" identified to lead of care issues.	Training – see 5.1.5. Champion - The Locality OPMH Matron has been asked to be a visible presence on the Hergest Unit to support staff and to act as champion.	Matron; OPMH Matron	31st March 2016
6. Training				
6.1 A standard approach needs to be applied to all staff files to ensure that evidence of all appointments is consistent.	6.1 Staff file audit to be undertaken against standard guidelines of what information should be held in paper copy and what information should be on ESR.	6.1 to begin in May 2016	Locality Manager	31st May 2016
6.2 A review of staffing is required and recruitment to some key posts is necessary to ensure wards are operating at full complement.	6.2 Ward clerk has been appointed and pending employment checks. Expected to start work by April 2016.	6.2 Complete	Matron	1stApril 2016
6.3 Staff morale, particularly on Taliesin ward needs improvement, with a specific focus on the time frame to resolve issues and staff dynamics.	See 3.1 Staff engagement exercise.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
6.4 Debriefing/lessons learnt must form part of staff communication to ensure good practices are continually re-enforced and risks mitigated as far as possible. There are processes in place to ensure that lessons learnt are presented to the West Governance Meeting and the Divisional Leadership Team, however cascade processes are needed to ensure information is shared with all staff in the team.	6.1 Locality Scorecard is being developed which will capture this information and provide a route for cascading through the teams.	6.2 Locality Scorecard is being developed.	Interim CRES Programme Manager	30th June 2016
7. Governance				
7.1 A review of the governance/audit systems and processes need to take place to ensure the health board has robust and adequate information conveyed to them.	7.1 Governance processes across the Division are currently being reviewed. The Division will have a formal Quality, Safety and Experience Committee to act as central hub for all governance and audit information and ensure the appropriate flow of this information up and down through the organisation.	7.1 New governance structures and processes are being developed and will be introduced over the year as processes are finalised.	Director of Nursing; Associate Director Governance	30th June 2016
7.2 All the areas identified must be addressed, specifically: 7.2.1 A recruitment strategy to fill the high number of RC vacancies	7.2.1 A recruitment plan was put to the Medical Director and Director of Workforce and Development in July 2015. The Divisional Clinical Director will continue to seek support for this plan at a Health Board level.	7.2.1 The Divisional Clinical Director will continue to seek support for this plan at Health Board level.	Divisional Clinical Director	31st December 2016
7.2.2 A bed management strategy to manage the demand of in-patient beds	7.2.2 See 2.2.4	See 2.2.4	Interim Programme Consultant	31st August 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
7.2.3 An acceptable time frame for the delivery of new furniture needs to be established	7.2.3 See 1.5.1; furniture is being delivered in February 2016.	7.2.3 New non-ligature beds have now been procured and are to be delivered on 17th February 2016.	Locality Manager	17th February 2016
7.2.4 A review of and strategy to deal with the issues on Taliesin ward regarding staff morale	7.2.4 See 3.1; staff engagement exercise.	3.1 Quality and Safety Lead supporting Locality Manager to begin implementation.	Locality Manager	31st August 2016
8. Monitoring the Mental Health Measure				
8.1 The review found that CTPs were not being appropriately updated to reflect inpatient care planning, including risk assessment, observations and Mental Health Measure documentation. There needs to be a consistent approach to management of CTPs from community and inpatient across the Division.	8.1.1 Locality Manager to discuss with colleagues in Central and East to understand how this issue is managed elsewhere.	8.1.1 Locality Manager to discuss in March.	Locality Manager	31st March 2016
	8.1.2 Results of that region-wide review to be discussed with Head of Nursing.	8.1.2 Locality Manager to present finding to Director of Nursing for consideration.	Director of Nursing	30 April 2016
	8.1.3 The Division will continue to monitor valid CTPs asa a percentage of team caseload: the standard set is 90%	8.1.3 On the 27th January 2016, the Division had achieved 85% compliance against this standard	Mental Health Measure lead: General Manager	30th June 2016
9. Application of the Mental Health Act				
9.1 Section 17 leave forms to be appropriately managed in line with the Mental Health Act.	9.1Reminder to all nursing staff regarding their responsibilities for ensuring forms are appropriately updated. Monitor appropriate updating of Section 17 leave forms through use of the monthly	The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	Locality Manager, Matron	1st April 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
	Quality Audit.			
9.2 Observational records should be signed and dated and filed in the patient's notes.	9.2Reminder to all nursing staff regarding their responsibilities for ensuring observational records and signed, dated and filed. Monitor quality of observational records through use of the monthly Quality Audit.	9.2 Confirmed at Senior Nurses Meeting 11th February 2016 that observational records should be signed and dated and filed in the patient's notes; to be reiterated and included in all Senior Nurses Meetings.	Locality Manager, Matron	Completed
9.3 Patients should be read their rights and offered the services of an IMHA, and this should be evident from the file. Processes already exist to ensure that this occurs at the time of a change to the patient's status; however there are currently no systems to ensure that patients are reminded of their rights or their access to an IMHA at relevant stages of their care.	9.3.1 Reminder to all nursing staff regarding their responsibilities for reminding patients of their rights and IMHA services, particularly at times when the patient's capacity is noted to have improved.	9.3.1 The monthly quality audit on each inpatient ward will provide a level of assurance required with daily monitoring by Ward Manager.	Locality Manager, Matron	1st April 2016
	9.3.2 Adapt checklist in order to provide prompts to nursing staff on reaffirming to patients their rights under s132 MHA and IMHA access at periodic intervals. This will need to apply cross-region.	9.3.2 Locality Manager to discuss with Mental Health Act Manager and Co-ordinator.	Locality Manager; Mental Health Act Manager	31 March 2016
9.4 Hospital Managers reports should be received in a timely manner.	9.4 Mental Health Act Co-ordinators to escalate any delays with Hospital Managers reports through the Daily Escalation Support Tool, to the Locality Manager or Divisional Clinical Director for action.	9.4 Mental Health Act Manager will issue reminder to all staff who prepare Hospital Managers reports that any delays will be escalated as a matter of urgency from now on.	Locality Manager; Mental Health Act Manager.	29thFebruary 2016
9.5 Robust systems should be in place	9.5.1 The Mental Health ActCo-	9.5.1 The Clinical	Mental Health	31st March 2016

Recommendation	Health Board Action	Progress towards action	Responsible Officer	Timescale
to ensure that locum doctors are checked for Approved Clinician and Section 12.2 status.	ordinator must be notified immediately, via the Clinical Services Co-ordinator, of any/all changes to the senior medical workforce, including the full name of the proposed locum, and geographical area of employment to be covered.	Services Co-ordinator is integrating an alert for the Mental Health Act Co-ordinators into existing processes.	Act Manager; Business Manager	
	9.5.2 Divisional Clinical Director to write to Office of the Medical Director to request priority is given to responding to requests for approval.	9.5.2 Divisional Clinical Director to write to Office of the Medical Director	Divisional Clinical Director	29th February 2016

Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report

Executive Summary

This report was commissioned by
Betsi Cadwaladr University Health Board

May 2018

Report Author:
Dr Androulla Johnstone:
Chief Executive Health and
Social Care Advisory Service Consultancy Limited
and Independent Investigation Chair

HASCAS
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Contents

1 Preface

1.1 The Independent Investigation into the care and treatment provided on Tawel Fan ward was commissioned formally by Betsi Cadwaladr University Health Board (BCUHB/the Health Board) in August 2015 pursuant to the Welsh Government (Version 3 – November 2013) *Putting Things Right: Guidance on Dealing with Concerns about the NHS from 1 April 2013*. The Investigation was commissioned initially to examine specific concerns raised by some 23 families about the care and treatment received by their loved ones between January 2007 and December 2013. At this time the 23 families were held on the BCUHB open concerns register. In order to identify any other patients whose care and treatment might have fallen below an acceptable standard the Investigation was also asked to examine the archives developed during the following prior processes:

1. The Ockenden external investigation (conducted in 2014 and published in May 2015).
2. The North Wales Police investigation (2014-2015).
3. The Betsi Cadwaladr Mortality Review (2015).

1.2 Consequently additional patients were added to the Investigation Cohort which rose to 108 in number. Separate confidential reports have been prepared detailing the findings in relation to each case.

1.3 The Investigation was also commissioned to provide human resource management reports for any person employed by the Health Board identified with either conduct or competency issues in relation to any established untoward events or substandard practice on Tawel Fan ward.

1.4 The care pathways followed, and care and treatment received, by the patients in the Investigation Cohort have been examined closely in order to identify the lessons for learning. It is a matter of public interest to understand exactly what occurred on Tawel Fan ward, how expressed concerns were escalated and managed, and to establish the lessons for learning relevant to both local and national service provision.

1.5 Investigations of this kind should aim to increase public confidence in statutory health service providers and to promote organisational competence. It is the duty of any Independent Investigation Panel to conduct its work in an impartial and objective manner. This Investigation has endeavoured to maintain an independent and evidence-based stance throughout the course of its work with the aim of providing as accurate account of events as the available evidence allows.

2 Acknowledgements

Patients, Families and Friends

2.1 The Investigation Panel would like to extend its sincere thanks to the patients, families and friends who have contributed to this work. For some individuals the process has been a demanding one whereby challenging and difficult experiences have had to be relived.

2.2 The Investigation Panel has heard, and taken into account, a wide variety of views and concerns. There has been no unified set of experiences put forward; family accounts differ greatly. For example: some families stated that in their view Tawel Fan ward was an abusive environment where their loved ones were mistreated, neglected and came to harm. Other families offered the view that the care and treatment their loved ones received was of a very good standard with staff showing kindness and compassion throughout their relative's entire episode of care.

2.3 The Investigation Panel acknowledges the lived experience of every person who has come forward and has endeavoured to provide a fair and balanced view based on an independent analysis of events.

2.4 It should be recognised that each individual who came forward to the Investigation, either in writing or in person, gave a significant amount of their time to the process. We are grateful to them for this.

Witnesses

2.5 Independent Investigations commissioned via NHS frameworks do not have the statutory powers to compel witnesses to take part in proceedings. Whilst individuals who were either employed by the NHS (or who were still active on a professional register) had a requirement to take part in the Investigation, those to whom these conditions did not apply could not be compelled to take part against their wishes. The Investigation would therefore like to thank all of those participating individuals who are currently retired or who no longer work in health related activities for coming forward voluntarily to assist with the inquiry process.

2.6 Those current NHS employees who were called to give evidence were asked to provide information about clinical and managerial practice. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Health Board's senior management team who have granted access to facilities and individuals throughout this process.

Support

2.7 Investigations of this kind can cause a significant degree of distress and trauma to all involved (families, patients and staff witnesses alike). Prior to the commencement of the investigation process there was a requirement to ensure expert and timely support was in place. BCUHB provided access to timely, easily accessible psychological triage and commissioned an independent counselling and trauma therapy service. The Investigation Panel would like to extend its thanks for the level of support that was provided and continues to be provided.

Multi-Agency Partners and External Stakeholders

2.8 The Investigation Panel acknowledges with gratitude the inputs received from Betsi Cadwaladr University Health Board's multi-agency partners together with the Nursing and Midwifery Council and General Medical Council for their assistance and cooperation throughout. We thank them for their patience and the professional courtesies they extended throughout the course of the Investigation.

3 Investigation Terms of Reference

3.1 The original Terms of Reference (ToR) for the Investigation were agreed by BCUHB at the Board meeting held on 8 September 2015. Minor amendments were made in July 2016.

Terms of Reference

"Betsi Cadwaladr University Health Board has commissioned HASCAS Consultancy Limited to provide the lead independent investigator role in relation to the complaints, concerns and disciplinary matters arising from the investigation into the failings of care on Tawel Fan Ward in the Ablett Unit at Ysbyty Glan Clwyd.

Remit

To provide independent and comprehensive investigation management and triangulation of all previous investigation material and evidence which will include:

- *Police investigation statements and written evidence.*
- *External investigation undertaken by Mrs Donna Ockenden and written evidence collated and sent through to the Police and published report.*
- *Complaint files and correspondence.*
- *Internal investigations commenced and suspended when Police investigations commenced.*
- *Mortality review and report.*
- *Any internal audit or external report/review or other information held by the Health Board which is deemed relevant.*
- *Provide family point of contact where additional information to support concerns has and is being provided, meeting with families who have made contact and collate their evidence.*

Purpose

With the evidence available, triangulate all sources of information which will enable the evidence to be collated into a comprehensive public facing document (redacted) and an internal document (un-redacted) and additionally provided into two streams of evidence for the purposes of:

(1) Complaints Management

- *Collated into patient specific evidence so that a comprehensive summary can be made in response to each formal complaint that will stand up to external scrutiny and enable each family to be confident that all information has been used in the response. Where health care issues have been identified or harm caused, the Putting Things Right (PTR) regulations are considered with regard to Regulation 24, 26 and 33 (Harm and Causation).*

(2) Professional Regulation and Employment policies and procedures

- *Collated into staff specific evidence, so that the information which needs to be considered where omissions in professional practice and breaches in clinical standards are evidenced are individualised into summary evidence which can be used as Statements of Case if appropriate for consideration under BCUHB employment policies and where necessary onward referral to the relevant regulatory bodies for example the General Medical Council (GMC) and Nursing & Midwifery Council (NMC). In addition consideration must be given to the notification and or referral to Disclosure and Barring Service (DBS)/Independent Safeguarding Authority (ISA).*

Escalation

If at any time new information is identified the appropriate action must be taken to ensure escalation in line with the relevant policies and procedures.

Timescales

The Investigation will complete the work program which has been set out in 5 stages.
First Stage: August/September 2015
Second Stage: September/October 2015
Third Stage: October/November 2015
Fourth Stage: December/January 2016
Fifth Stage: January/February 2016

Reporting

In keeping with other large and complex NHS investigations a formal governance assurance process has been established for the Tawel Fan HASCAS Investigation.

Team and Resources

The Executive Director of Workforce and Organisational Development will be the Lead Executive Director on behalf of the Board overseeing these arrangements. This role will be supported by a team of senior managers who will provide the required Input and the professional expertise to contribute to the work of HASCAS who will lead the Investigation".

3.2 It should be noted that the Investigation underwent significant time slippage and the dates for the completion of each stage were not met. This was due principally to the Investigation Panel not being able to access key documentation in a timely manner.

4 Summary of General Findings and Key Lessons for Learning

Investigation Context

4.1 There always have been, and probably always will be, occasions when NHS services fail to deliver against the standards that it strives to achieve. The pressures that NHS services face are reported frequently in the media together with the recognition that patient care is sometimes compromised. It is important to recognise that this state of affairs, whilst regrettable, occurs for a number of reasons as part of the ebb and flow of daily service provision within the NHS.

4.2 The Investigation Panel does not seek to be an apologist for the NHS in general, or for BCUHB or Tawel Fan ward in particular, however it would be both unrealistic and unreasonable to visit harsher tests than those deemed to be acceptable for any other NHS service currently delivering patient care under the normal day-to-day pressures that are encountered throughout the United Kingdom. It has therefore been essential for the Investigation Panel to work in a manner proportionate to the circumstances and the available evidence base.

4.3 The Investigation Panel concludes that the care and treatment provided on Tawel Fan ward was of a good overall general standard even though there were key areas identified where clinical practice and process required development and modernisation.

4.4 Nevertheless it was also identified that, on occasions, the experience of some patients and their families was compromised due to a combination of systemic failures exacerbated by significant financial restrictions, poor service design and ineffective governance arrangements. However it should be understood that these issues were not as a result of any failings in relation to Tawel Fan ward *per se* but were encountered by patients and their families across a wide range of services on the care pathway that they travelled.

4.5 These issues encompassed problems from the point of first diagnosis through to (and often past) the point of discharge from Tawel Fan ward and/or the eventual death of a patient. These issues also included the lack of dementia friendly Accident and Emergency Department inputs and the difficulties patients and families encountered on medical wards and with other BCUHB services.

4.6 Tawel Fan was the common denominator in that of the 108 patients in the Investigation Cohort 105 were admitted onto the ward for a period of time. However it is evident that many of the concerns and complaints raised by families did not relate to the ward and that a significant number of families had nothing but praise for the care and treatment their loved ones received on Tawel Fan and for the kind and compassionate care provided by members of the treating team.

4.7 This view was not shared by all of the families in the Investigation Cohort; the Investigation Panel encountered significant dissonance between the accounts provided by family members. It has been a key responsibility of the Investigation Panel to ensure that no single view or family stance took precedence over any other and that all findings and conclusions were made after extensive examination and triangulation of the evidence available. It was also the responsibility of the Investigation Panel to ensure that the focus remained upon lessons for learning rather than calls for punishment and retribution which were entirely disproportionate to the actual findings and conclusions of the multidisciplinary expert Investigation Panel.

4.8 Whilst the Investigation Panel found the care and treatment provided on Tawel Fan ward to be of a good overall general standard, there were nine key factors that served on occasions to compromise the quality of the patient and family experience during the period of time under investigation. These factors are set out below and apply to the experience of the older adult (and their families) across the whole care pathway encountered including Accident and Emergency Departments, medical wards, old age psychiatry and community-based care.

Summary of General Findings

Factors Impacting upon Patient Care

4.9 **Governance.** During the period of time under investigation governance processes (both corporate and clinical) were weak across the whole of the BCUHB provision; this served to disrupt strategy development and implementation. This also served to prevent a robust approach from being taken in relation to patient safety in that evidenced-based practice and organisational learning were under-developed and could not always be relied upon to provide the levels of protection that were required.

4.10 Clinical governance provides the means to ensure patient safety and quality improvement; its effectiveness (or lack of it) has a direct impact on service delivery. In the most basic of terms the care and treatment delivered by BCUHB services was often compromised by:

- poor quality clinical policies and guidelines that did not always provide an appropriate and evidence-based set of standards for practice (particularly in relation to the older adult);
- limited training and education opportunities for staff;
- an ineffective approach to patient safety alerts such as those raised by complaints, incidents and safeguarding referrals;
- inadequate levels of capacity and capability in relation to the workforce in general and medical and nurse staffing in particular;
- ineffective clinical information systems which compromised access to individual patient information in a timely manner.

4.11 **The Care Pathway.** Most of the patients in the Investigation Cohort experienced problems with the care pathway that they encountered. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as

those for medicine and psychiatry, often served to create significant barriers which had a negative impact upon patients and the timely access to the care and treatment that they required. As a result patients often experienced:

- delays and restrictions when accessing the most appropriate clinical service (for example: inpatient medical care and hospice beds);
- distress and loss of dignity (caused by prolonged delays in A&E departments and medical assessment units);
- compromised care and treatment that was sometimes provided in clinical environments that were suboptimal;
- hospital acquired infections and injuries (exacerbated by delayed transfers of care);
- compromised levels of health, safety and wellbeing;
- multiple moves driven by service rather than clinical need with a subsequent loss of patient trust and confidence.

4.12 **Financial Pressures and the Consequences for Patient Care.** The financial pressures that BCUHB faced from the point of its inception (and including the period of time under investigation) made a significant contribution to both bed shortages and restrictions to service access (across the system as a whole). The organisation had to fund service developments from a 'zero funding base'. This meant that one service had to close before another could be developed. The interim period often caused pressures within the system (for example: when older adult psychiatric inpatient beds had to be closed during 2012 in order to develop community services) until the new service redesign benefits could work through the system; this had the effect of raising inpatient acuity levels.

4.13 Financial restrictions also placed pressures on staff recruitment practice which meant that clinical services could not recruit to staff vacancies in a timely manner. As inpatient acuity levels rose as a consequence of overlapping service redesign initiatives, the ability to access a workforce with the required capacity and capability reduced. Consequently competing financial pressures served to restrict access to services, increased patient acuity causing 'bottle necks' and delayed transfers of care, and reduced access to a workforce that could provide the levels of skilled care and treatment required.

4.14 **The Clinical Environment.** The clinical environment on Tawel Fan ward was not optimal for the patient cohort receiving their care and treatment there. The ward design did not lend itself to the safe management of the confused elderly person and the ward layout could not be adapted to provide single-sex accommodation.

4.15 In addition, over the years, the fittings and fixtures of the ward had deteriorated and constituted both a risk to health (for example: worn carpets which were trip hazards) and a decline in the quality of the patient experience (for example: the inability of the Ablett Unit boiler to provide a consistent supply of hot water).

4.16 **Care and Treatment.** The levels of care and treatment provided on Tawel Fan ward were of a good overall general standard. From the evidence available it is evident that good nursing care was provided and that the Fundamentals of Care

were maintained well. However on occasions care and treatment did not comply in full with national policy expectation and this meant a consistent and evidence-based approach was not always taken. Of particular note were issues in relation to:

- the management of falls;
- medications management;
- access to therapies (such as occupational therapy, speech and language therapy and psychological services);
- the formal recording of clinical risk assessment.

4.17 Nevertheless a key finding of this Investigation is that the care and treatment on Tawel Fan ward was in general safe and effective as evidenced by the contemporaneous clinical records, internal and external reviews and inspections, patient outcomes, and the evidence provided by a significant number of families who provided information to this Investigation.

4.18 **Safeguarding.** Systems and structures within BCUHB were not always robust enough to support the protection of adults at risk. This was exacerbated by a general lack of consistency on the part of Local Authority partners as to what constituted abuse and how this should be managed. Safeguarding referrals took a long time to process and did not meet the timescales prerequisite in policy guidance. This meant that Tawel Fan ward staff had to manage risks in the interim period without the level of external scrutiny and support required. There was an inability of the system to aggregate safeguarding trends (such as increasing patient acuity and rising levels of patient-on-patient assault) in order to formulate management strategies and workforce responses.

4.19 Despite problems with the system there is no evidence to suggest that Tawel Fan ward was an environment where abusive practice took place either as a result of uncaring staff who acted wilfully in an inappropriate manner, or due to a system that failed to protect. There is no evidence to support findings of abuse from a perspective of cruel or inhumane treatment and neither is there any evidence to support the notion of institutional abuse or neglect.

4.20 **Legislative Frameworks.** The Investigation Panel found that when patients were detained on Tawel Fan ward under the Mental Health Act (1983) processes were managed appropriately and in accordance with the legislation and Code of Practice.

4.21 However it was evident that on occasions patients who had been admitted informally should have been assessed under the Act with a view to formal detention. This is because those patients met the threshold for assessment and it was not always clear under which legal framework they were being kept in hospital and provided with care and treatment. In addition, apparent acquiescence was often taken to indicate that a patient did not need to have an assessment under the Act; however as they did not have the capacity to consent to admission and treatment they were in fact detained but without the legal protections afforded to patients sectioned under the legislation.

4.22 **Carer and Family Support.** During the period under investigation the levels of advice, supportive coordination, counselling and education provided to patients and their families were of an inconsistent standard at the point of first diagnosis. For many patients and their families this served to create confusion throughout the dementia journey that they embarked upon.

4.23 Consequently patients and their families were not always able to plan for the future in an informed manner and on occasions this compromised the levels of trust and confidence they had in NHS services and also compromised their ability to make decisions and be effective co-partners in care and treatment planning.

4.24 **The Clinical Record and Professional Communication.** During the period of time under investigation BCUHB operated (and operates still) a hard-copy clinical records system. Recording templates were inconsistent and were not subject to audit. This meant that the quality of the clinical records varied enormously.

4.25 Of particular concern was the archiving and retrieval system which meant that clinical records could not always be accessed with ease by members of treating teams. This created problems with continuity and, at times, compromised the efficacy of patient care.

Key Lessons for Learning

Patient and Family Support

1 **Counselling.** There is a need for a more comprehensive and specialist range of pre and post diagnostic counselling opportunities for patients and their families. Regardless of how well members of the treating team try to communicate diagnostic information they are to some extent boundaried by their primary clinical roles and functions. It is naïve to expect individual clinicians, no matter how caring and compassionate they are, to be able to provide a consultation in a memory clinic, or a ward-based family meeting context, in *lieu* of formal counselling.

2 **Dementia Coordination and Signposting.** There is a need for the better coordination of patients and their families from the point of first diagnosis; this is in keeping with Welsh Government strategy. Continuity of care and relationship building are essential factors when working with patients and their families over a long period of time, especially as the dementia process is both challenging and progressive.

If BCUHB is to meet the Welsh Government challenge to increase dementia diagnostic rates at increasingly early stages of the condition, an additional resource in relation to support will be required. This will need to be addressed as part of the current BCUHB Mental Health Strategy as increased success in one area will inevitably lead to service pressures in another.

3 **Clarification at the Point of Admission.** When admissions take place during times of crisis it is difficult for families to understand what is happening and what they are being asked to agree to. It is important to clarify events and revisit the decisions made and the subsequent consequences once the admission is complete and the patient has been made safe. It is not good practice for misunderstandings to arise; however on occasions these will be inevitable. To minimise the likelihood of this it is important that families are provided with a clear account of events as soon as is possible and that plans for the immediate future are discussed with them moving forward.

4 **Operational Policy Synchronisation.** In order to provide a streamlined service that can meet expectations it is necessary for there to be a consistent set of criteria in place to guide the care pathway. Operational policies should be developed from an 'integrated' service perspective so that patients and their families can be signposted correctly and reliably.

5 **Living Well with Dementia.** Over recent years a more positive and community-based approach to living with Dementia has grown. Clinical services need to ensure that they are in step with this ethos and assessment and care and treatment planning needs to focus on holistic need with the aim of providing meaningful person-centred care which does not focus on disease processes alone.

6 **Education, Information and Support to Patients and their Families.** People need access to education, information and support throughout their journey with dementia. 'Frontloaded' inputs at the point of diagnosis are not enough, and neither are meetings and consultations with members of treating teams once a person has reached a point of crisis. Consideration needs to be given as to how information can be provided and tailored to each stage of the journey, particularly at key points of transition such as admission to acute inpatient wards or eventual placement in care homes. It should also be understood that family support needs will be ongoing and they should be re-assessed and provided for in a dynamic manner.

7 **Communication Practice across all NHS Services.** Patient and family communication issues were identified in relation to Accident and Emergency, medical and surgical services. There is an obvious need for all NHS services to communicate well; however a key lesson for learning is that all services should (in addition) be dementia aware and appreciate the fact that family members often have to give consent for their loved ones who are no longer able to do this for themselves.

8 **Placing the Patient at the Centre of Decision Making.** The best interests of the patient should always be at the centre of any decisions made. When there are ongoing disputes between families and treating teams these disputes should be recorded and independent advice sought. It is essential that delays to important decisions are avoided (such as admission or discharge) as these can have a negative impact on the safety and welfare of the patient.

9 **Co-production of Care and Treatment Plans.** If adequate education, information and support is provided then people with dementia and their families will be empowered to co-produce care and treatment plans. The co-production of care and treatment plans should be about *"how do you want to live your life"* from the outset of the dementia journey.[1] The process of ascertaining preferred options in relation to treatment (and gaining knowledge about the person) should begin from the first point of contact.

Clinical Governance

10 **Documentation and Clinical Recording.** Where hard copy documentation systems exist clinicians have to work harder when both accessing information and recording it. This can present additional workforce challenges within often highly pressured services.

The hard copy clinical record system as it operated in BCUHB (and operates still) was not always reliable and caused significant problems in relation to both the transmission and transcription of clinical information. It is essential that standardised procedures are established so that records can be traced and accessed in a reliable and timely manner. Standardisation is also essential in relation to clinical documentation so that hard copy records capture all of the essentials of baseline assessment.

11 **Policy Guidance.** Clinical governance systems should provide as a minimum a clear set of policy guidance together with a set of organisational expectations about professional standards. National guidance provides clear best practice guidance for clinicians (regardless of discipline). It is the responsibility of each individual to ensure they are up-to-date and that they work within this guidance. However it is the corporate responsibility to highlight this guidance and to ensure that adherence is monitored and the quality of clinical care and treatment assured.

12 **The Management of Complaints and Concerns.** It is essential that families and their loved ones are informed about how to raise complaints and/or concerns and how these will be managed; where appropriate patients and their families should have access to advocacy services. Clear guidance should also be provided in relation to the management of investigation outcomes. Families should be advised that if they are not happy with investigation outcomes, and if their issues have not been addressed to their satisfaction by the NHS PTR process, then they should contact the Ombudsman. Health services should not endeavour to resolve complaints and concerns beyond the point advised in the All Wales Putting Things Right guidance. This can undermine the process and create a confrontational and intractable situation which is counterproductive and where neither side can move forward.

13 **Professional Standardisation.** Evidence-based clinical guidance and practice adherence is a key tenet of clinical governance. Without systems to ensure access, implementation, monitoring and review the quality of the

1 NHS Wales (2013) *Tools for Improvement 8 1000 Lives Co-Producing Services – Co-Creating Health*

patient experience can be compromised and suboptimal practice and/or unsafe practice provided.

14 **Policy Development.** Policy guidance should be tailor made to the needs of the older adult. It is poor practice to subsume them into policies produced for adults of working age whereby the evidence-base in relation to older adults is ignored and care and treatment guidance compromised as a result.

15 **Professional Leadership and Escalation.** When wards are under pressure it is essential that managers and senior clinical practitioners are available to provide advice, leadership and support. During 2013 when Tawel Fan ward was under its most significant period of pressure it was evident that the ward team were able to rely increasingly upon the Modern Matron, the Dementia Nurse Consultant and senior CPG managers. This ensured that (whilst care and treatment and service management issues arose) overarching safety was maintained whenever possible.

Legislative Frameworks

16 **Mental Capacity, Best Interests and Advocacy.** Legislative frameworks must be deployed for patients deemed to have a loss of capacity when making specific treatment decisions. This is of particular importance for those patients who are not detained under the Mental Health Act (1983). The use of independent advocates should be an integral part of any service provided.

17 **Patient-Centred Care.** It is important that care giving is flexible and sensitive enough to ensure dignity, health, wellbeing and safety whilst at the same time allowing the patient sufficient autonomy wherever possible. This applies to all patients, but is particularly relevant for those deemed to no longer have the capacity to make decisions on their own behalf. There should be no 'one size fits all approach' and care plans should take into account the needs and preferences of each individual patient which always take preference over those of families and services alike whenever appropriate to do so.

18 **Family Communications, Engagement and Support.** Legal frameworks are complicated to understand and often associated with preconceptions and stigma. It is important to ensure that each family member is acknowledged in accordance with their particular roles (Lasting Power of Attorney, nearest relative and/or next of kin) and their rights are both explained to them and supported. Strategies need to be agreed and put in place so that communication is effective (and bears in mind the needs of large families) without contravening due process in relation to decision making and confidentiality.

19 **The Need for Clarity Regarding Legal Frameworks.** NHS organisations must provide clear guidance to services about the use of the Mental Health Act (1983) and the Mental Capacity Act (2005); the guidance should clarify how they must work together and which takes precedence over the other and in what circumstances. These guidelines should be kept under review and audited where necessary on a patient-by-patient basis.

20 **The Protections that Legal Frameworks Afford to the Patient.** The Mental Health Act (1983) should not be seen as a punitive and restrictive option for the older adult with advanced dementia. Instead it should be seen as the framework under which individuals are protected and their rights upheld.

21 **The Importance of the Independent Mental Capacity Advocate (IMCA).** Under the Mental Capacity Act (2005) all patients have the right to access an IMCA. This is important when complex and difficult decisions have to be made in the patient's best interests as an independent advocate should always be accessed to ensure they are maintained and protected. When there are disputes between family members and the treating team the input from an IMCA is essential to ensure the patient's needs are paramount and that they are addressed in the best manner possible.

22 **The use of Legislative Frameworks.** Even if families are engaged in full, when difficult decisions have to be made in relation to care and treatment risk versus benefit analyses, Do Not Attempt Resuscitation (DNAR), end of life care and any planned changes to a clinical placement an Independent Mental Capacity Advocate should be involved where the patient is deemed not to have the capacity to make decisions on their own behalf.

23 **Accident and Emergency Departments and Medical Wards.** When elderly confused people are admitted to these kinds of NHS facilities the requirements of the MHA (1983) and MCA (2005) cannot be 'suspended'. They apply equally to all care and treatment environments where a patient meets the threshold for assessment and intervention under the Acts. All treatment decisions need to be recorded clearly and any issues in relation to capacity, consent and DoLS should be made explicit and managed in keeping with Acts. The failure to do so could result in illegal detention and the potential for improper care and treatment interventions.

Medication and Treatment

24 **Psychotropic Medications – Documentation and Standardised Evaluation Processes.** Psychotropic medications carry an inherent degree of risk. It is always good practice to adhere to National Institute for Health and Care Excellence (NICE) guidance and to ensure that documentation is completed in a systematic manner. This will ensure a comprehensive record is made of all decisions taken and will assist with a logical and evidence-based evaluation process. Where there are no pre-set organisational standards or clear levels of expectation clinical practice is determined by individual practitioners and might not always be optimal.

25 **Risk Assessment.** Risk assessment is a key cornerstone of clinical practice. As such it should be prioritised and conducted as a core multidisciplinary function. All aspects of clinical risk should be recorded and subsequent care plans documented clearly so that explicit rationales for clinical decision taking are set out and patients are protected.

Efficacy of the Care Pathway

26 **Resourcing.** Patients who are acutely unwell and in crisis require the highest levels of expertise and resource. It is poor practice for financial pressures to remove essential services from wards like Tawel Fan (such as occupational therapy and routine physiotherapy). The quality of the patient experience is reduced, the quality of the care and treatment compromised and the length of stay potentially lengthened. This kind of cost saving is both counter productive and ineffective. Care and treatment approaches should be multidisciplinary in nature. The older adult suffering from dementia often has a range of comorbidities and needs. It is naïve to assume these can be met by a 'traditional' doctor and nurse treating team.

27 **Transitions between Secondary and Primary Care.** The transition point between secondary care and primary care ought to be examined. Arrangements need to be agreed in relation to specialist assessment, monitoring and review once a person has been discharged back to the care of their General Practitioner. This is to ensure that antipsychotic medication is not used as a 'maintenance medication' and that all benefits and risk are kept under regular review.

28 **Access to Medical Assessment.** Psychiatric inpatients should not experience lower levels of medical assessment access than those to be expected in a community setting.

29 **Management of the Elderly Confused Patient in Acute Secondary Care.** Accident and Emergency Departments and Medical Wards must ensure that the care and treatment provided to elderly confused patients is person-centred, dignified and safe. It is not acceptable for them to be left for hours without food and drink, nursed in corridors, or left unsupervised encountering numerous falls that could be prevented with better assessment and management plans.

30 **Strategic Planning and Multiple Moves.** Service provision should be as integrated and person-centred as possible so that patients can experience smooth transitions of care which ensure optimal clinical outcomes and inspire trust and confidence. It is not acceptable for patient care to be compromised by rigid boundaries between services. It has long been recognised that multiple inpatient moves have been associated with raised rates of morbidity and mortality. It is never acceptable for multiple moves to be conducted to meet the needs of the service as opposed to the needs of the patient.

31 **Risk Assessment and Service Modernisation.** Service improvement and modernisation requires financial and service re-modelling. Improvements that require the concurrent running down of one service whilst another is built up carries inherent risks over the period required to enact the change; wards like Tawel Fan can be expected to absorb the pressures. The risks to the system and its ability to manage extant patient services should be understood and compensated for, particularly when specific groups of patients can be readily identified to be placed at additional risk during change management processes.

Safeguarding

32 **Connectivity between Multi-agency Partners.** Safeguarding frameworks require a consistent and unified approach. Despite the challenges posed by geographies (such as county and statutory agency boundaries) systems and processes have to be robust enough to provide person-centred safety measures. The Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse (first version 2010 and second version 2013) required small Unitary and Local Authorities to work together to ensure consistency and safety across geographical areas; it also required full cooperation between the NHS and Social Services. It is an essential lesson for learning that safeguarding systems and processes have to be managed across boundaries if they are to achieve their primary goal to safeguard adults at risk.

33 **Prioritisation and Adequate Resourcing.** Safeguarding adults at risk cannot be compromised by an organisation's perceived inability to adequately resource the systems and processes required. All NHS and Local Authority bodies are required to conduct themselves in accordance with policy guidance and any capacity and/or capability shortfalls should be addressed and managed so that their statutory duties can be fulfilled.

5 Overview of Conclusions and Recommendations

Overview of Conclusions

General Conclusions

5.1 The findings and conclusions in relation to BCUHB governance and systems failures have been identified previously by multiple review processes which have already been placed in the public domain. If an organisation operates with inadequate governance arrangements then the likelihood of poor service provision is heightened together with an increased inability to identify and remedy failings and patient safety problems. The findings and conclusions of this particular Investigation concur with those previous findings but also makes a separate and distinct contribution in relation to the following:

- the patient care pathway and service design;
- patient acuity and restrictions to service provision;
- evidence-based practice and the care and treatment of the older adult.

5.2 Any investigation process that undertakes an examination of care and treatment that took place a number of years ago has to differentiate between findings and conclusions that are 'historic' in nature and where practice has moved on and improved, and those where practice remains of a suboptimal nature and where urgent remedial action is required in the here and now.

5.3 The three points listed above have been identified by the Investigation Panel as being the basic underlying factors that made a distinct contribution to suboptimal care and treatment provision in the past and which the available evidence suggests are either still unresolved or in a relatively embryonic stage of service improvement and implementation.

The Patient Care Pathway and Service Design

5.4 One of the most significant findings of this Investigation is in relation to the fragmented care pathway followed by the majority of the patients in the Investigation Cohort; most of the patients in the Investigation Cohort experienced problems with the care pathway that they were placed on. Service interfaces between the disparate BCUHB Clinical Programme Groups (CPGs), such as those for medicine and psychiatry, often served to create significant boundaries which had a negative impact upon patients and the timely access to the care and treatment that they required.

5.5 Older adults are placed at significant risk when care pathways are not managed well. Disruptions to care pathways are known to increase the likelihood of hospital acquired infections and injuries and, on occasions, death. The poor management of the older person's care pathway across north Wales is a key finding of this Investigation. The lack of strategic direction and oversight,

combined with significant financial restrictions, meant that each separate CPG within BCUHB was allowed to develop levels of service provision without any interconnectivity in play. This led to a set of systems that functioned independently of each other and which could not address the day-to-day challenges posed by patients moving between services to the detriment of their health, safety and wellbeing.

5.6 There has been insufficient evidence provided to the Investigation Panel to suggest that in practical terms the experience of a patient would be significantly different today in comparison to that of patients from the Investigation Cohort. This is an area that requires priority and urgent action.

Patient Acuity and Restrictions to Service Provision

5.7 The Investigation Panel established that patient acuity rose on Tawel Fan in the years prior to its closure due to:

- the reduction of care home beds;
- a relatively embryonic community-based Home Treatment Team that could not manage patients in their own homes once they had reached crisis;
- reductions to the numbers of older adult inpatient beds across the Mental Health and Learning Disability CPG.

5.8 This situation was exacerbated by additional pressures placed on mental health services by Emergency Departments, inadequate Out of Hours provision and restricted access to medical and hospice services.

5.9 It is recognised widely in Wales that the number of people with dementia is rising steadily and will continue to rise. Pressures on nursing home beds remain and there is evidence to suggest that community-based services remain under-developed and that older people with dementia still experience compromises in relation to the kinds of service they can be offered in community, primary and secondary care settings.

5.10 The challenges for BCUHB and its multi-agency partners in 2018 is to provide a range of services that do not discriminate against those individuals with dementia and to ensure that a diagnosis of dementia is not one of exclusion or compromise.

Evidence-Based Practice and the Care and Treatment of the Older Adult

5.11 During the period of time under investigation BCUHB did not provide evidence-based clinical policies that pertained to the particular needs of the older adult with dementia and/or mental health problems. The needs of the older adult were subsumed into those for adults of working age which was entirely inappropriate. This lack of evidence-based guidance exacerbated fractures in service provision and led to a high degree of confusion on the part of the treating teams responsible for providing care and treatment.

5.12 Of particular concern was the fact that clinical practice was not subject to audit in the manner prescribed within the United Kingdom for the past twenty years. This meant that clinicians were left largely to 'their own devices' and that there were no structured clinical governance structures in place to ensure patient safety.

5.13 The Investigation Panel heard evidence from many senior clinicians during the course of its work. From the testimonies provided by those witnesses it would appear that the custom and practice around the development and auditing of clinical practice guidance within BCUHB is still in a somewhat embryonic stage. Witnesses described the work as 'being part of a journey', or 'not yet having reached its destination'. This is not acceptable for a modern NHS service and will require urgent and priority actions to take place.

5.14 Part of the challenge that BCUHB needs to face is the underlying culture of resistance to clinical policy uniformity and regulation. The Investigation Panel established that a key barrier to progress being made is predominantly one of custom and practice and that there are views still retained by some senior clinicians within the organisation that the clinical decision-making process should not be overseen by formal governance and management structures. This is exacerbated by a lack of organisational confidence and ethos in relation to formal oversight and performance management as a legacy of the highly devolved and medically-led service model that prevailed for many years within BCUHB.

The Issue of Wilful and Institutional Abuse and Neglect

5.15 The nature and scale of any failures in relation to patient care on Tawel Fan ward cannot be compared to those of the Stafford Public Inquiry or the Trusted to Care Independent Investigation (conducted in Wales), on either a macro (system) or micro (individual patient) level.

5.16 Neither of those robust and universally accepted reports set their findings within the context of institutional abuse or concluded that care and treatment deficits occurred within the context of an abusive system (even though care and treatment fell well below those standards commonly accepted by the general public and statutory services alike). The Investigation Panel concludes that this approach has to be maintained in relation to the circumstances encountered by patients and their families on Tawel Fan ward, especially as the standards of care on the ward have been found to be of a good overall general standard, even though on occasions care and treatment practice across the pathway was compromised.

5.17 The Investigation Panel could not replicate the specific findings of abuse from any of the earlier investigations and reviews that did. This does not mean that the Investigation Panel can categorically state that abuse on an individual patient basis *never* took place on Tawel Fan ward; no investigation of this kind could ever make such a bold statement. However the Investigation Panel can, and does, conclude that the evidence relied upon previously was:

- incomplete; and/or
- misinterpreted; and/or
- taken out of context; and/or
- based on inaccurate (and at times misleading) information; and/or
- misunderstood with thresholds being applied incorrectly.

5.18 The Investigation Panel therefore concludes that there is no evidence to support prior allegations that patients suffered from deliberate abuse or wilful neglect or that the system failed to deliver care and treatment in a manner that could be determined to meet the thresholds for institutional abuse.

5.19 It is essential that this conclusion is made in the clearest and most unambiguous of terms in order to restore public confidence and to ensure natural justice is served.

Safeguarding

5.20 Adult safeguarding frameworks exist purely to provide protection for adults at risk of abuse and neglect; they work at two levels. First: at a multi-agency Local Authorities are the lead agencies and are tasked to bring statutory and other agencies together to co-ordinate the development of effective policies and procedures to protect those at risk. Second: at a single agency level, each organisation must develop its own set of procedures that meet the requirements of the multi-agency framework and legislation, and deliver adult safeguarding services to protect adults at risk of abuse or neglect.

5.21 This Investigation found that the systems and processes in place during the period under investigation were not operating in an optimal manner and the expectations and requirements of the multi-agency policy documentation of the time were not met in full. At a multi-agency level, whilst the six Local Authorities endeavoured to bring agencies together around adult safeguarding for their areas, there is no doubt that the formation of the large Health Board in 2009 disrupted the pre-existing relationships that had developed over the years between local health and social care agencies.

5.22 Each of the Local Authorities developed their own approach to adult safeguarding under the umbrella of the *Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse (2010 and 2013)*. Each developed their own safeguarding referral paperwork and it was reported to the Investigation Panel that there were differing referral thresholds in place. Systems and processes did not allow easy tracking of safeguarding information. Referrals were made by name and home address and did not monitor the place of abuse thereby making it difficult for Local Authority safeguarding staff to spot trends from particular clinical areas. In addition, individuals at this time were moving across both agency and geographic boundaries due to closures of care beds. It appears that safeguarding information did not readily follow individuals at risk across geographical boundaries and this built risk into the system.

5.23 These arrangements made it very difficult for clinical staff in the ward areas to navigate the adult safeguarding system easily. There were delays in the process of safeguarding, which often moved outside of the timescales in the policy, and ward staff who were responsible for the protection of the individual whilst they were in their care, often did not receive feedback in terms of what had been decided within the safeguarding meetings rendering ongoing protection and decisions regarding discharge, difficult.

5.24 During the period of time under Investigation there were poor safeguarding record storage and retrieval processes. This resulted in staff being unclear about what protection processes they were supposed to be putting in place and how to best deal with relatives when they were considered to be a risk to the individual in their care. As a result, information to individuals, families and carers was not conveyed clearly which led to confused expectations and understanding of what was happening.

5.25 In relation to BCUHB processes, the Investigation Panel found that adult safeguarding had not been well resourced and each CPG had been allowed to develop its own processes and structures. In addition, Board oversight was not strong and the Executive and Independent Members were not advised clearly of the problems relating to adult safeguarding in either the multi-agency partnership or specific clinical areas. Audit systems during this period of time were rudimentary, so opportunities for BCUHB to triangulate data about safeguarding referrals were lost.

5.26 At the time of writing this report there was evidence to suggest that good foundation work is taking place in relation to the restructuring and resourcing of the internal BCUHB safeguarding frameworks and processes. However a substantial amount of service development is still required in order to ensure safeguarding works to protect adults at risk across north Wales as many of the issues identified by the Investigation Panel are still a problem within current service provision. The Investigation Panel concludes that this constitutes essential and priority work for the organisation and those responsible for its performance management moving forward.

Summary of General Conclusions Specific to Clinical Care and Treatment

5.27 Many of the findings and conclusions made specifically in relation to Tawel Fan are to a large extent redundant as the ward is now closed. However there are key issues that have been identified in relation to clinical practice that need to be highlighted as they are relevant to the care and treatment of the older adult and/or those with dementia regardless of clinical setting.

5.28 Many of the findings of the 2014 *Trusted to Care* report dovetail into those of this Investigation. Basically the needs of the older adult and those with dementia require specialist nursing and medical care and treatment. Older adult services should not be seen as 'Cinderella' services but should be recognised as priority services that require clinical staff with expert skills and access to specialist

training. Resources should be ring-fenced to ensure that neither old age nor dementia exclude any individual from accessing appropriate and timely care and treatment.

5.29 During the period under investigation older adult and dementia services were neither planned nor coordinated with the degree of organisational strategic oversight that was required. This not only made an impact upon the quality of the care pathway patients and their families encountered, but also made a direct impact upon the effectiveness of the care and treatment that they received.

5.30 It is of significance that during the period of time under investigation there were no older adult or mental health clinical specialists at Board level or within the senior corporate team. Inspections, strategy and assurance processes were overseen by those with limited expertise and a limited understanding of what evidence-based service provision and care and treatment should look like.

5.31 At the present time significant work has taken place to make services more aware of the needs of the older adult and those with dementia. However the approach taken remains rather *ad hoc* with separate clinical divisions approaching these issues differently. The work currently being undertaken is primarily being led by the mental health division and BCUHB needs to move away from the stance that dementia is primarily the concern of mental health services and embrace a different ethos where the Health Board accepts the care and treatment challenges of old age and of dementia embrace all health and social care provision in all care and treatment settings. However one very positive step has been the decision to appoint a dedicated dementia specialist into the corporate nursing team to ensure that in future a more integrated approach is taken; in this manner resources are beginning to be aligned to support pace and consistency.

5.32 Moving forward BCUHB needs to ensure all aspects of clinical governance come together to ensure the particular needs of the older adult and those with dementia are met. This needs to include workforce capacity and capability, education and training, clinical audit and evidence-based practice guidance, patient safety and safeguarding. Alongside this costed and timed strategic plans need to be developed spanning the entire of breadth of service provision to ensure the needs of the older adult and those with dementia are inbuilt into every service and care and treatment context. The work that needs to be undertaken *must* be built across all executive teams and clinical divisions to ensure full integration and a unified strategic ethos.

Recommendations

Overview

5.33 The setting of recommendations is a primary task for any investigation process. In the case of BCUHB the situation is complex in that the organisation is currently subject to action plans stemming from various other investigation, review and performance management processes; it should also be taken into account that at the time of writing this report the organisation was still subject to

Special Measures. Not all of these issues are related directly to Tawel Fan ward or older peoples' mental health services, but many share a degree of interconnectivity.

5.34 The Investigation Panel has not been privy to all of the outstanding issues or the levels of progress made by BCUHB to-date. To this end the recommendations fall into two distinct categories – the first requiring a concerted degree of oversight (and possible further development) from Welsh Government in relation to ongoing high-level performance issues, and the second requiring practical, operational service change within BCUHB requiring a less intensive level of oversight from external bodies.

5.35 In addition BCUHB will soon be in receipt of the Ockenden Governance Review. This review will provide a significant number of recommendations in relation to governance systems, structures and processes. Consequently this Investigation has limited the setting of its recommendations to strategic and specific clinical practice issues. Following the publication of the Ockenden Governance Review further work will need to be undertaken to provide synergy in relation to action planning and the recommendations from both of the separate investigative and review processes.

5.36 On reviewing the progress made by BCUHB in relation to many of the current recommendations it is working to, it is evident that moving forward *all* future recommendations need to be overseen with the support of a structured action plan that sets:

- clear milestones, aims and objectives;
- clear performance targets and indicators;
- clear methods of audit and evidence collection, progress review and assurance;
- clear costings and resource implications;
- clear indications of where multi-agency inputs are required;
- clear timeframes and completion dates;
- clear methods of accountability and oversight.

5.37 With this in mind the Investigation Panel has reviewed the progress made by BCUHB in relation to the findings and conclusions of this Investigation. The recommendations have been set with the intention of supporting the work that BCUHB has already embarked upon and to also ensure that future strategic planning incorporates inputs from Welsh Government particularly where multi-agency partners also need to make significant contributions to planning, process and service provision.

5.38 The Investigation Panel has identified that during the period of time under investigation, and into the present day, many BCUHB initiatives have either been confounded or rendered ineffective by a lack of integrated, strategic thinking and planning. The recommendations set out below place emphasis on the importance of joined-up thinking and integrated service planning. The expectation is that all recommendations will be completed within 12 months of the publication of this report.

Category One: High-Level Recommendations Requiring External Oversight and Further Development

The Dementia Care Pathway and Service Design

Progress Made

5.39 BCUHB has developed a series of initiatives to improve the quality of the patient and family experience when accessing services for the older adult with dementia. There is a newly developed 'Care Pathway for Patients Developed with Dementia on Medical Wards'. There is also a 'Carer's Passport' initiative which improves the access and practical support available to carers when visiting their loved ones in clinical settings. This is all good practice.

Progress Required

5.40 It is not the intention of the Investigation Panel to detract from the work that is currently taking place within BCUHB. However the newly developed Care Pathway document focuses solely upon very basic patient and carer support and nursing care standards. The care pathway work and service redesign work that is still required is more complex and strategic in nature.

Recommendation One: Care Pathway and Service Design

- An integrated service review is required to map the needs of the older adult and those with dementia across north Wales. This review needs to involve all stakeholders (from the statutory, independent and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those confined to mental health and older adult services) in order to ensure that all interventions are integrated and that patients, service users and their families do not encounter service barriers that prevent them from receiving access to the care, treatment and support that they need.

- The review outcomes and options should underpin all current and future health and social care strategies across north Wales and be overseen by the appropriate performance management and inspection bodies.

Implementation of the National Wales Dementia Strategy

Progress Made

5.41 BCUHB has made significant progress in relation to many key areas detailed within the Wales Dementia Strategy:

1 The Health Board has a designated Consultant Nurse in Dementia care who provides input at a strategic and clinical level into services.

2 There are currently a wide range of opportunities for patients and families to obtain support through memory services and the third sector (such as the Alzheimer's Society). In addition BCUHB dementia training is now open for

families and carers to participate in. This training has been developed alongside families and carers who have provided evaluation. Across the Health Board there are an increasing number of Nurse Specialists with enhanced skill sets to provide ongoing support to patients with dementia and their families/carers.

3 There is a Delirium and Dementia Specialist Nurse available to provide expertise to individuals and services. There has also been a strong focus on the recruitment of Dementia Support Workers who are working across the organisation together with ten Dementia Activity Workers who are further supporting patients when accessing mental health services.

4 The Flynn and Eley Review highlighted the importance of support for those affected by or living with dementia at or around the point of diagnosis. They recommended that BCUHB develop a standard offer of post diagnostic support for people living with dementia and their families as part of a wider network of support.

Significant progress has been made in respect of this recommendation. Memory services have been redeveloped and mapped to local need so that supportive interventions can be offered in each locality in the language of choice supported by dementia support workers and third sector organisations. In the first year of operating over 700 new patients accepted the offer of meeting with a Dementia Support Worker and from that cohort 54 percent have gone on to receive further input.

5 BCUHB has produced a Dementia Handbook in conjunction with the Alzheimer's Society which is given to patients and their families at the point of diagnosis.

Progress Required

5.42 The Investigation Panel acknowledges the steady progress that BCUHB has made in relation to patient and carer support. However a great deal of work still needs to be done. At present the Dementia Strategy is a high-level document that will require further detailed action planning if it is to be implemented in a consistent and sustainable manner. The progress already made (as listed above), together with the progress still needing to be made, should be subsumed into a distinct strategy implementation programme which is supported by a costed and timed action plan.

Recommendation Two: Dementia Strategy

- BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with Recommendation One. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the Mental Health Directorate) in all care and treatment settings (community, primary and secondary care).

- The action plan should take into account all of the clinical and practice deficits that have been highlighted by this Investigation and will require independent clinical input and oversight.

- Access to therapy and non-medical interventions and treatments should be an integral part of any costed Dementia Strategy plan which takes into account NICE (and all other) best practice guidance in this regard. The capacity and capability of the workforce should be reviewed to ensure that fit for purpose services can be provided. Implementation should be managed and audited in tandem with Recommendation Ten (see below) as the reduction of the use of antipsychotic medication will to a large extent be predicated upon alternative therapeutic interventions being made available.

- Formal audit and performance management arrangements should be agreed and built into the action plan.

Care Home Provision in North Wales

Progress Made

5.43 BCUHB has been working proactively to support the care home sector. The initiatives that have been put in place include:

1 **Practice Development Team**. This team is responsible for ensuring the delivery of quality, evidence-based and personalised care within the homes. They undertake annual quality monitoring audits utilising an electronic tool that scores the delivery of care associated with Healthcare Standards and the Fundamentals of Care. The team facilitates and delivers training in-house and can arrange for specialist nurse support to provide clinical leadership.

2 **Quality Assurance Framework**. This has been developed to describe and set out quality assurance processes to ensure safe care. This includes holding a monthly clinical management group to proactively discuss each care home with all relevant stakeholders. This helps to gain and collate key intelligence and provides a robust and proactive response in order to support homes as required.

3 **Contracts and Fees**. The Health Board has employed a contracts team. This team works to explicit performance indicators and can work with the Practice Development Team to raise quality and provide practical support directly into any care home experiencing difficulties.

Work is ongoing to ensure the sustainability of the market in conjunction with the need for quality and safe care provision. This work is currently being undertaken with the North Wales Care Home Market Group which incorporates health and Local Authority inputs to sustain access to the market. Membership from this group also works with the National Commissioning Board care home agenda.

4 **Home First**. The Home First Initiative was launched in response to the National Care Home census data undertaken by the National Commissioning Board which identified that BCUHB had a higher percentage of patients in care homes with increased average lengths of stay in comparison to other Health Boards in Wales. This project will reduce the pressure on the care home sector by reducing the demand and thus increasing the bed capacity and availability for those who need such placements.

Progress Required

5.44 The Investigation Panel acknowledges the progress that is being made in this area. Moving forward this progress needs to be audited and any ongoing work programmes need to form part of an integrated process that brings together the BCUHB Mental Health Strategy, the Dementia Strategy and all ongoing service re-design initiatives; particularly those changes and improvements to community support provision.

5.45 A fragile care-home market can impact greatly upon NHS community, primary and secondary care services. Care home provision and quality monitoring needs to be unified into wider strategic action planning as part of an integrated approach to providing timely access to appropriate and good quality services.

Recommendation Three: Care Homes and Service Integration

- The current Care Home work streams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB Mental Health and Dementia Strategies.

Safeguarding

Progress Made

5.46 The BCUHB safeguarding service has been realigned, to incorporate strengthened safeguarding governance, with a focus on prevention and protection. New roles, where team members work across clinical areas in a proactive manner, are being implemented whilst maintaining specialisms. The realigned service incorporates the previously stand-alone services of DoLS, Safeguarding Adults and Children, and Tissue Viability, along with specialised individuals including a Safeguarding Dementia lead.

Progress Required

5.47 At the time of writing this report there were significant areas that still required improvement. However the Investigation Panel acknowledges the fact that BCUHB is aware of the areas that require improvement and is reassured by the levels of increased insight and understanding of its safeguarding responsibilities. BCUHB have identified ongoing issues:

- the current safeguarding training programme is not fit for purpose and requires updating;
- staff are not attending safeguarding training in the numbers required;

- the current database is immature and lacks the ability to triangulate data from IT and reporting databases throughout the organisation;
- the problems with the storage and retrieval of hard copy safeguarding information remains in keeping with the findings of this Investigation;
- there have been difficulties in resourcing the new safeguarding structures in a timely manner;
- governance processes require review in relation to safeguarding policy and process.

Recommendation Four: Safeguarding Training

- BCUHB will revise its safeguarding training programme to ensure it is up-to-date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance.

- BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation.

- BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.

Recommendation Five: Safeguarding Informatics and Documentation

- BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 are implemented – namely:

  - the use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity;
  - process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance;
  - team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs.

- In addition BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided. This to include specific guidance on:

  - the content of protection plans;
  - the recording of strategy meetings and all decisions taken (guidance should require a standardised approach across all BCUHB clinical divisions);
  - formal monitoring and review templates should be developed and audited to ensure safeguarding timescales are met and those with key responsibilities in this regard held to account.

- BCUHB will repeat the audit within 12 months of the publication of this report to ensure that all clinical areas are compliant.

Recommendation Six: Safeguarding Policy and Procedure

- The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This Investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are:

  - *"to identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners;*
  - *agree a priority list and activity timeframe to review documents within the parameters of Corporate Safeguarding;*
  - *provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy and legislative safeguarding frameworks;*
  - *agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs;*
  - *update and maintain the Safeguarding Policy webpage;*
  - *continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards".*

Recommendation Seven: The Tracking of Adults at Risk across North Wales

- BCUHB will work with multi-agency partners, through the North Wales Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual.

Recommendation Eight: Evaluation of Revised BCUHB Safeguarding Structures

- BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.

Category Two: Recommendations Concerning Localised Operational Service Change

Informatics and Clinical Records

Progress Made

5.48 The Investigation Panel is aware of the initiatives currently in train to introduce an electronic clinical records system within BCUHB. This work is to be encouraged for the future.

Progress Required

5.49 The issues in relation to the extant hard-copy clinical records and the systems currently in place to store and retrieve them remain a problem that requires priority action in the here and now. The Investigation Panel noted that around 50 percent of the clinical records that it had access to were commingled one patient with another. The Investigation Panel also noted that BCUHB found it difficult to compile complete sets of clinical records; whilst the majority of the patients in the Investigation were deceased, approximately 30 percent of the patients were still living at the beginning of the investigative process. It is of concern that BCUHB could not access complete sets of clinical information for a cohort of living patients and calls into question BCUHB's ability to ensure clinical information is accessible when needed in the interests of continuity of care and patient safety.

Recommendation Nine: Clinical Records

- BCUHB needs to undertake a detailed check of the clinical records in the investigation cohort to evaluate and re-order all commingled casenotes.
- BCUHB needs to ensure that none of the commingling involving living patients could have led to any inappropriate acts or omissions on the part of clinical treatment teams during any episode of care (past and present).
- BCUHB needs to restructure and redesign its hard copy clinical records archiving and retrieval systems. This redesign needs to provide assurance in relation to the tracking of individual casenotes across north Wales together with a set of service level agreements pinpointing the timeframes required for clinical record retrieval and access.

Medications Management and the Use and Monitoring of Antipsychotic Medications

Progress Made

5.50 Internal BCUHB audits concur with the general findings and conclusions of this Investigation in relation to the use of antipsychotic medication in community and primary care settings. BCUHB provided the following information:

"A pilot project was carried out in 2012 where consultants and GPs shared a 3 monthly review of antipsychotic treatment which led to an improvement in the rate of review and reduction in prescribing. However this was not sustainable and it was concluded that this review was better carried out by nursing or pharmacy staff. An aide memoire was developed and the study presented at numerous collaborative events in 2012 and 2013 and to Care Forum Wales.

Prescribing guidance was agreed within the MHLD Division in 2015 and Aide Memoire sent round to GPs as well as several visits to increase awareness.

The baseline audit from GPs across BCUHB was carried out during 2017 in order to establish the extent of prescribing. The results showed about 10% people with dementia prescribed an antipsychotic in Central, 11% in the west and 18% in the East.

The audit recorded whether a medication review had been carried out in the last 6 months. The majority of the people with dementia had a general medication review documented as part of the care home enhanced service or dementia review. Any patients who required further clarification on the need for antipsychotic could be referred to the MH specialist team.

An audit of antipsychotic prescribing in 2015 and again in 2017 in secondary care demonstrated that although prescribing was deemed appropriate in many cases based on target symptoms, there was lack of documented risk assessment and discussion with the carer / patient or ongoing management plans.

As a result the 2015 guideline has been updated and a proforma developed to aid documentation of antipsychotic prescribing and review. Prescribers were asked to pilot this proforma in 2017 and work is ongoing to raise awareness of the importance of including a clear indication and duration for antipsychotic treatment in older people and the need for ongoing monitoring. A training needs analysis and implementation plan will be incorporated into the guidance.

Current Situation

The updated guidance is currently in consultation and reflects the need for greater collaboration and communication across care settings to ensure that patients are reviewed after being discharged to the GP. The review should be undertaken in collaboration with the carer(s). If the GP/practice staff are unable to review or have concerns then the patient should be referred to the community mental health team for advice and support.

A Patient Safety Notice has been drafted to highlight the issue of inappropriate continuation of antipsychotics as the issue extends beyond mental health and into the general hospital where people may be started on antipsychotics for delirium. It is therefore felt that the Patient Safety group should oversee the process of ensuring that people with dementia prescribed an antipsychotic have a documented risk assessment, indication and review date.

Work has been ongoing to raise awareness of this issue and this year a baseline was obtained in primary care which has helped highlight outlying practices who may require support to review their patients. This support has been provided by a limited resource of mental health pharmacists, as well as the mental health community teams.

Ongoing audits in primary and secondary care, and education will be carried out until the process of prescribing review is embedded in practice across primary and secondary care.

Clinicians in both primary and secondary care will be continually reminded to ensure that they follow national and local recommendations to review and reduce antipsychotics medication where appropriate. There may be situations where ongoing use is justified and this must be clearly documented.

Given that antipsychotic medication is used in those who may have lost a care home placement on account of challenging behaviours, there is still considerable work to be done to train carers in managing challenging behaviours without using medication in order to allow the gradual reduction and stop without the fear of re-escalation of behaviours and subsequent failure of placement".

Progress Required

5.51 The Investigation Panel supports in full the very comprehensive work that BCUHB has conducted in relation to the prescribing and monitoring of antipsychotic medication. It is evident that work is ongoing and the following recommendation is set in order to support further the remaining actions that require completion.

Recommendation Ten: The Prescribing and Monitoring of Antipsychotic Medication

- The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12 month period of the publication of this report.

- BCUHB will continue to work with care homes across north Wales to provide practical clinical advice, guidance and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of antipsychotic medication possible. The effectiveness of this should be built into the antipsychotic prescribing guidance audit detailed in the bullet point directly above.

Evidence-Based Practice and Clinical Guidelines

Progress Made and Still Required

5.52 BCUHB has not been able to provide any progress update in relation to governance processes regarding evidence-based practice and clinical guidelines. It is evident from the information provided to the Investigation Panel that the processes underpinning the development and monitoring of clinical policies and procedures within BCUHB is inconsistent and on occasions clinical staff do not have access to the most up-to-date best practice guidance. The amount of work that needs to be undertaken is significant and will require a detailed risk assessment and focused and timed action plan.

Recommendation Eleven: Evidence-Based Practice

- BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet. As part of this work:
  - A risk assessment should be conducted to prioritise the work that needs to be undertaken and to establish whether there are any urgent policy revisions and alerts required to ensure patient safety is maintained.
  - Work should be undertaken to review the extant clinical policies across the three BCUHB geographical regions to determine corporate ratification and fitness for purpose.
  - All clinical policies should be reviewed with the specific needs of the older adult in mind. Policies should either be re-written to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified in detail, or separate clinical policies and procedures should be developed for this particular patient cohort. This work should be conducted with expert multidisciplinary inputs.

Legislative Frameworks: Deprivation of Liberty Safeguards (DoLS)

Progress Made

5.53 The 'BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017- 2018' sets out a robust overview of current practice together with the work that BCUHB is still required to achieve.

Progress Required

5.54 The BCUHB Annual Report sets out a work plan which at the time of writing this report was close to completion. The work plan includes:

- *"Review DoLS Policy, Procedures and Guidance in consultation with other partners in Wales i.e.; Health Boards, Local Authorities, Healthcare Inspectorate Wales and Welsh Government to identify priority changes, plans and actions.*
- *Consult with the Professional Advisory Group implementation of a recently devised draft "Gold Standard" DoLS Application Form to improve quality and practice within all clinical areas.*
- *Reporting DoLS and MCA issues and activity across Corporate Safeguarding Areas to raise awareness and implications for practice.*
- *To review the role, responsibilities and functions of the signatories within the Supervisory Body to ensure it is fully compliant to governance expectations and continues to be fit for purpose.*
- *To review the current arrangements for recording DoLS data so it is more streamlined and fit for purpose in monitoring and reporting annually to HIW.*
- *A barrier to full integration of this provision within clinical areas is the lack of office accommodation on acute and community sites".*

Recommendation Twelve: DoLS

- BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018 – 2019.

The Management of Aggression in the Elderly

Progress Made

5.55 The BCUHB 'Assurance Report – Older Peoples' Mental Health Service December 2017' states that:

"In May 2015, the National Institute for Health and Care Excellence published 'NG10', their latest guidelines relating to the management of aggression and violence in health care settings. Until this release, the vast majority of health providers in the UK were implementing reactive strategies to manage incidence of violence and as a consequence there has been a national drive to move away from the reactive paradigm towards a proactive approach which is emphasised in the guidelines".

5.56 Since this time BCUHB has stressed the need for providing the least restrictive procedures possible when managing patients who are exhibiting aggressive behaviours. BCUHB has taken part in a benchmarking exercise with other services in Wales. The Mental Health Division has:

"In response to the changing needs of OPMH [Older Peoples' Mental Health] services, the division has reviewed Restrictive Physical Intervention (RPI) training to ensure that practices taught are commensurate with the needs of our older population. All OPMH clinical personnel undergo a comprehensive five day training package and are assessed for competency prior to certification. Training meets the requirements of the current 'All Wales Passport Scheme' and compliance rates are monitored and reported through governance structures".

Progress Required

5.57 The Investigation Panel acknowledges the progress made by BCUHB in relation to reducing restrictive practices in older peoples' mental health services. The evidence provided suggests that safe and current best practice guidance is being implemented. However there needs to be an assurance that all care and treatment settings within BCUHB (Emergency Departments, medical wards etc.) are working to the same policies and procedures and that all staff involved with restrictive practice incidents are trained to the appropriate standard and that all incidents are recorded and form part of the BCUHB organisational learning cycle.

Recommendation Thirteen: Restrictive Practice Guidance

- BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision. BCUHB will also ensure that the *Royal College of Psychiatrists' Centre for Quality Improvement (March 2007) National Audit for Violence: Standards for In-patient Mental Health Services* guidance is embedded in all training and policy documentation in relation to 'taking dementia patients to the floor' during restrictive interventions.

End of Life Care

Progress Made

5.58 The BCUHB 'Assurance Report – Older Peoples' Mental Health (OPMH) Service December 2017' states that:

- *"Through 2018 Memory Service staff will have the skills and knowledge to hold accurate and sensitive conversations about End of Life preferences.*
- *OPMH link staff supported by specialist hospice nurses and palliative care nurses will assure dignified End of Life care on in-patient wards".*

5.59 The Assurance Report states that *"innovations involving all memory services and OPMH in-patient wards. Memory services are opening the conversation about advance directives with people newly diagnosed with dementia. Such is the sensitivity of this that staff are still undergoing training from specialist hospice nurses".*

Progress Required

5.60 Dementia is a life-limiting condition. Of some concern is the prevailing BCUHB stance that end of life care can be provided appropriately on Older Peoples' Mental Health wards. The rationale provided by BCUHB is that this is to prevent any unnecessary distress caused by a transfer to another care setting.

5.61 The Investigation Panel acknowledges that many families and their loved ones experienced a good standard of end of life care on Tawel Fan ward (and many continue to do so in other similar environments). However not all families report positive experiences. It remains a fact that acute psychiatric admission wards are not optimal places for end of life care to take place due to the conflicting needs of the patient cohort. Of concern would be the retention of patients on acute psychiatric admission wards due to difficulties in finding suitable alternative placements (such as a medical or hospice bed) and/or a lack of timely and suitable transportation. The environment for end of life care has to provide dignified, safe and clinically appropriate care. Regardless of the levels of expert input into care planning from hospice and palliative care staff there will always be circumstances where robust care inputs cannot mitigate against an inappropriate care and treatment setting.

Recommendation Fourteen: Care Advance Directives and Support to Patients and Families

- BCUHB has made significant progress in providing support to patients and families when holding end of life conversations and developing advance directives. This is good practice. BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care.

Recommendation Fifteen: End of Life Care Environments

- All older adults and people with dementia have the right to the same access to quality end of life care as any other individual (of any age) with any other condition. If a person is to receive end of life care on an older person's mental health ward (and in particular an acute admission ward) the following should always be undertaken:

  - a clinical risk assessment to determine the appropriateness of end of life care being provided in an older people's mental health facility – the risk assessment should take into account the levels of patient acuity and any potential conflicts that could be present;
  - an assurance that out of hours medical cover can be provided if the patient's physical condition requires it;
  - an assurance that equipment can be resourced with the minimum of delay and that patients are never nursed on mattresses on the floor due to a shortage of hi/low beds;
  - an assurance that patients can be supervised appropriately and not left unattended due to other challenges that ward might face;
  - an assessment to confirm patients can be nursed in quiet and peaceful environments and that the ward layout can accommodate this;
  - an incident form should be completed if a patient receives end of life care due to a lack of appropriate alternative placements and difficulties with transport;
  - consultation with relatives who should be able to request the transfer of their loved one to a different clinical setting if they feel a mental health facility is in any way unsafe or inappropriate;
  - the training of all registered nursing staff (including night staff) in end of life and palliative care.

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19th March 2018

Vaughan Gething
Cabinet Secretary for Health & Social Services
BY EMAIL ONLY

[redacted]

Dear Cabinet Secretary,

Betsi Cadwaladr UHB – Lack of Progress under Special Measures

I write on behalf of the members of North Wales Community Health Council to express their growing concern about the failure of Betsi Cadwaladr University Health Board to emerge from its period in Special Measures. North Wales CHC members have had a growing concern about this situation and it is at their request that I drafted a letter setting down those concerns. We have had two meetings with members of the BCUHB Board to discuss the content of this letter and they recognise our concerns. We have amended the letter in the light of comments we received during those meetings.

Following the 100 day Plan, there was an initial improvement and further improvements occured with the appointment of the current Chief Executive in early 2016. North Wales CHC were keen to provide support and encouragement for the reconstituted Board and, in consequence, North Wales CHC was positive about the steps being made to address the five key improvements areas that your predecessor listed as requiring urgent attention;

- governance, leadership and oversight;
- mental health services;
- maternity services at Ysbyty Glan Clwyd;
- GP and primary care services, including out of hours services;
- reconnecting with the public and regaining the public's confidence.

Specifically, we have been pleased to see improvements in the following areas:

- improvements in the working relationships between senior leaders
- responsibility for Putting Things Right transferred to the Executive Director of Nursing and Midwifery
- we regard the Board's use of social media for communication with patients and the public as an exemplar
- GP out of hours service – there has been a marked improvement in rota fill rates
- The new strategy for mental health services, Together for Mental Health, was developed with extensive input from service users and other stakeholders.
- The Health Board diverted an additional £5 million from elsewhere in the system in order to provide an increased level of support to the Mental Health Division and its services.
- We note that the WAO Structured Assessment highlighted that BCUHB's corporate arrangements for savings planning and delivery are becoming stronger and that significant financial savings have been delivered.

Nevertheless, we are now almost three years into Special Measures and the pace of improvement has slowed. There is a belief amongst CHC members that Special Measures is now the "*new normal*" for the Betsi Cadwaladr Board and appears to have lost its impact. We are not the only people who believe this. Our members' extensive contact with the public during our widespread public engagement sessions this summer confirmed that there is lack of public confidence in the current "*Betsi*" Board being able to deliver the healthcare that the public in North Wales expects.

Additionally, examination of Board minutes over the previous three years will support our view that, despite some improvement, there is still insufficient challenge from Independent Members and an absence of

any debate or concerns from those members about failures in the delivery of service, many of which are reported in the press and media on a regular basis.

You will know that the recent Deloittes Report, although heavily redacted for the public, has this to say;

- *"In our view, executive level leadership capability and capacity needs to be enhanced. It will also require a "strengthening of financial and strategic capability amongst independent members".*
- *"Financial and Strategic Planning at the Health Board is simplistic with budgets generally rolled forward into next year."*
- *"There is a distinct lack of secondary questioning from Board members to facilitate detailed debate and discussion across the key areas of risk".*
- *"The Finance and Performance Committee is spread too thinly, its role is poorly defined and misunderstood by Board members".*

The report makes other worrying statements;

- *"It is acknowledged by interviewees that the HB has not explicitly focussed on strategy development in recent years due to high levels of turnover in Executive Directors and a focus on shorter term operational issues".*
- *"In our view change management arrangements at the HB are not fit for purpose and remain a significant obstacle towards delivering sustainable change. Plans are underway to consolidate the various activities but we have concerns over whether the capability exists to successfully drive this agenda".*

The Deloittes Report shows that areas highlighted for improvement in the June 2017 Joint WAO/HIW Report have failed to progress sufficiently. We know that you share our concerns about the lack of progress and said recently;

> *"It has been disheartening and unacceptable that during 2017/18 issues have escalated in Betsi Cadwaladr UHB in relation to the financial position and some key areas of*

performance. This has resulted in the Welsh Government increasing its oversight, including my personal chairing of monthly accountability meetings since July".

In relation to the Board's strategic planning capabilities, the Deloittes Report says that the BCUHB flagship strategic initiative "Living Healthier, Staying Well" consists of a "*very high level of strategic objectives but provides limited guidance regarding the specifics behind the plan*". It is the CHCs experience that this echoes much of the Board's planning – a great deal of time and effort is expended on creating strategic plans which are then never acted upon.

A consistent criticism of BCUHB over many years has been that the creation of a plan that can be kept on the shelf and referred to periodically is seen as the end of the process, with no one taking responsibility for delivery and change management. Worryingly, Deloittes say that "*we are concerned that the Integrated Medium Term Plan is being used inappropriately as a primary driver of strategy*" and that "*Living Healthier, Staying Well" is being used to populate the Medium Term Plan without developing the detail behind the plan*".

In relation to the five areas of concern originally highlighted by Special Measures, we feel we must especially express our worries about the provision of Mental Health Care. You will be aware that Conwy Council expressed concern about the safety of community based mental health care provided jointly with BCUHB. A report to Conwy Council said;

"cultural, managerial and leadership" issues at BCUHB had been impeding satisfactory progress" in community mental health services.

Initially Conwy Council had suggested that they might withdraw from joint provision if things did not but at a recent Council meeting the Council's Service Manager for Vulnerable People, said that weekly meetings were now in place and BCUHB had experienced a "*reality check*". We understand that this situation has now been resolved but we believe that it should never have arisen.

Suicide rates have been a particular concern in recent years and on 14th February 2018 the North Wales Coroner, John Gittins, delivered a highly critical report about the suicide of a young person in Wrexham. He said

there had been lengthy delays in transferring the patient's care from Flintshire to Wrexham community mental health service and that this led to "*missed opportunities*" to improve the patient's mental health. Mr Gittins said there was a "*risk future deaths will occur*" unless changes were made.

Criticisms about the provision of current and future mental health care as identified in recent HIW reports and coroner's inquests do nothing to raise public confidence in the quality of mental health care in North Wales. All six of our Local Committees have included monitoring of mental health care in their Annual Plans for the coming year. CHC visiting teams have been making regular unannounced visits to mental health wards and in some key areas their findings have shown a persistent lack of progress.

The fifth key improvement area was reconnecting with the public and regaining public confidence. Our experience is that waiting times are an important factor in public confidence. Whilst BCUHB might have marginally better performance in some specialities that other LHBs, the facts are that, at the end of 2017, 10,469 patients had been waiting more than 36 weeks for treatment, despite your clear instruction in October 2016 that the "*people in Wales must have timely access to services based on clinical need*". You said that 95% of all ages should be treated within 26 weeks and no-one should wait beyond 36 weeks. At the end of 2017 10,469 patients were waiting longer than this.

Your October 2016 instruction also stated that ailments must be diagnosed early and that no-one should wait for diagnostic tests beyond 8 weeks. Despite this clear instruction, at the end of 2017, 1,135 patients experienced waits over 8 weeks for their diagnostic tests.

You also instructed Local Health Boards that 95% of A&E attendees should be helped within 4 hours and that no-one should spend over 12 hours in A&E. In North Wales at the end of December 2017, only 72.5% of those seeking help received it within 4 hours. A quarter of those attending A&E were let down. 1,470 patients were kept in A&E for more than 12 hours. A major factor in this may have been an inadequate number of beds in acute and community hospitals because of permanent and temporary closures. *We informed you about our recent report that suggested that, on any given day, nearly 20% of the*

published bed numbers in North Wales are temporarily closed for a variety of reasons.

160 patients were referred to Betsi Cadwaladr with Urgent Suspected Cancers. Your October 2016 instruction stated that at least 152 of them should have been treated within 62 days. Only 140 patients were treated, 12 short of the target and leaving 20 urgent suspected cancer patients, largely those needing endoscopies or radiology, with treatment delays contrary to your instructions. Despite this the new endoscopy system planned for Ysbyty Gwynedd has been delayed until March.

BCUHB is struggling with serious GP recruitment issues in North Wales. The CHC is seeing a stream of practices closures where the partners retire together and it becomes necessary for the Board to step in and directly manage the practice. Over the past 3 years we have seen a tenfold increase in the number of directly managed practices. This rate of increase is not something that can be sustained and BCUHB is in need of Welsh Government support to cope with this situation.

The Board's performance on complaints and concerns has not been adequate and seems to have concentrated on higher level management reorganisation rather than addressing the root causes of delay and dissatisfaction. The same issues and concerns are raised repeatedly but this seems to make no impact on everyday practice. In fairness, this is the case for many other NHS organisations across but most have them have not been in Special Measures for nearly three years.

When your predecessor placed the Betsi Cadwaladr Board into Special Measures in June 2015 it was not because of one major issue but rather a variety of failings across the range of its activities. This signalled that this was a Board in crisis without the capability or capacity to address the issues it faced and in need of significant levels of help.

North Wales CHC believes that we are again at that point and this is despite almost three years in Special Measures. We note that you have brought in David Jenkins but, in reality, this is simply replacing the previous post-holder (*a highly competent retired NHS Executive with a great deal of experience*) who held virtually the same role since the start of Special Measures. We note also that there are appointments to be made into new posts including a Turnaround Director and hope that the

Board is able to recruit people with the necessary skill sets to fill these posts.

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North Wales CHC members, who have sought to be constructive and supportive in response to Betsi Cadwaladr UHB's improvement initiatives, believe that the recovery task is now beyond the oversight of a few key individuals and that it is time to consider escalating current support; taking whatever action you consider necessary to achieve a first class health service for the people of North Wales in a timely manner. In this context, support does not mean simply pointing out the areas where the Board is failing. In preparing this letter, we met with the Chair, Chief Executive and other key Board members to discuss this letter. It is clear to us that the Board is well aware of the challenges it faces and the areas that need improvement.

The difficulty is that some of these problems are beyond their control and need a partnership approach between the Board and Welsh Government with both taking responsibility for service improvement. For example, GP and Consultant recruitment and retention is a complex area that needs action at a national level as well as local; the financial challenges facing BCUHB can only be resolved in the long term – 10 years rather than 3 and it could be argued that the funding formula is not appropriate to the needs of North Wales.

We strongly urge joined-up working between Betsi Cadwaladr University Health Board and Welsh Government, with both taking responsibility for improvement, if we are ever to address the lack of confidence in the NHS in North Wales.

Yours sincerely

Jackie Allen
Chair – North Wales CHC

Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref VG/00970/18

Jackie Allen
Chair
North Wales Community Health Council
Units 1B & 1D Wilkinson Business Park
Clywedog Road South, Wrexham Industrial Estate
Wrexham
LL13 9AE

Geoff.Ryall-Harvey@waleschc.org.uk

13 April 2018

Dear Jackie,

Thank you for your letter of 19 March raising the North Wales Community Health Council concerns on lack of progress under special measures at Betsi Cadwaladr University Health Board (BCUHB).

I note from your letter that you had discussed the content of the letter with members of the BCUHB Board.

In your letter you referred to initial progress under special measures and that the Welsh Government, Wales Audit Office and HealthCare Inspectorate Wales had also reported on evidence of green shoots of recovery in the first two years. You outlined in your letter some of the areas in which you have been pleased to see improvements.

I would also note the significant improvements made in maternity services, including a reduced reliance on locum/agency staff (rate to 11% from 50%); compliance with Birthrate Plus; the re-introduction of pre-registration midwifery students to Ysbyty Glan Clwyd so that all three sites in North Wales are now being fully utilised for training purposes; appointment of a Consultant Midwife to lead improvements in midwife led care; and progress on the development of the SuRNICC. Given the good progress and stability demonstrated, I announced in February that this no longer represented a special measures concern and was therefore de-escalated as an issue.

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
0300 0604400
Gohebiaeth.Vaughan.Gething@llyw.cymru
Correspondence.Vaughan.Gething@gov.wales

I am disappointed to hear the view of your members that special measures is the 'new norm' for the Health Board and the lack of confidence in the Board to deliver the healthcare the public in North Wales expects. My focus is on ensuring the improvements expected are delivered by the Health Board in order that we can de-escalate the organisation. That is why I have been holding accountability meetings with the Chair and Chief Executive on a monthly basis. I have also set out additional support, actions and key milestones that I expect the Health Board to have achieved or progressed by April 2018, including responding fully to the recommendations set out in the Deloitte report. Key priorities are enhancing the capacity and capability of the executive and non-executive members of the Board and strengthening strategic and service planning expertise to develop an IMTP in partnership that is focussed on delivery.

On mental health services, I recognised in my statement in February that the absence of the Director of Mental Health and the Mental Health Nurse Director on extended sick leave had meant the improvements in this area had lost momentum in recent months. I was clear on the urgent need to embed and build on the new mental health leadership structure and speed up the pace of quality improvement to urgently rebuild confidence in the safety and sustainability of the existing mental health services, alongside beginning the longer- term transformational change set out in the new strategy. This will now be set out in a thematic quality improvement and governance plan for mental health services that I expect to be discussed at the May Board meeting.

You rightly noted that waiting times are an important factor in public confidence and performance on planned and unscheduled care is included under the special measures arrangements. Betsi Cadwaladr University Health Board was allocated the highest level of funding from the performance fund available for 2017-18 to improve referral to treatment waiting times and diagnostic waits.

On unscheduled care, the current performance is not acceptable and I have agreed additional funding of £1.5 million over two years for an unscheduled care programme to drive forward immediate and longer term sustainable improvements. We are continually working with the Health Board to further identify areas of support to drive progress in all the areas of concern.

I also note your concerns on urgent suspected cancer and GP recruitment. These challenges are similar across the NHS in Wales, and indeed the rest of the UK. The Welsh Government is working with health boards across Wales and continuing to invest in the estate and the NHS workforce to increase capacity. The new endoscopy system at Ysbyty Gwynedd and the two day surgery / endoscopy modular theatres at Wrexham Maelor Hospital will help ensure patients are treated within the timelines agreed and increase the attractiveness of north Wales to potential new staff. We exceeded our GP training target for this year, due in part to the success of our international recruitment campaign to encourage more medical professionals to choose Wales as a place to train, work and live. The Welsh Government has also received proposals from Bangor, Cardiff and Swansea Universities, working together, aimed at increasing opportunities for medical education and training in north Wales. These are currently being considered.

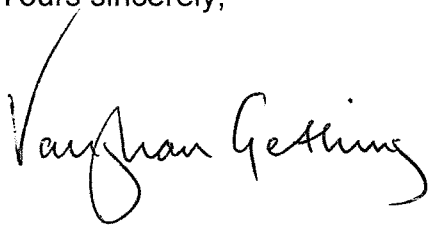
On the financial challenges facing the Health Board, it is evident that the organisation needs to develop and implement improved financial, service and workforce plans to recover and realise the opportunities available, and to also deliver on the transformational change required to move to a more sustainable position. I will be putting in additional support to build capacity and capability in its financial planning for the short, medium and long term.

I am unsure what is meant by your comment that the current funding formula is inappropriate to the needs of North Wales as assessment, shared with Health Board officers, indicates that its actual allocation under existing arrangements is higher than it would be under a needs based formula.

I fully recognise the need to ensure the Health Board has the capacity and capability to drive forward the improvements needed. My officials are working jointly with the Health Board to recruit people to key roles and to put in place advisory support in specific areas, including David Jenkins on leadership and governance and Emrys Elias on mental health services. The appointment of a new Chair will also be completed in the next month.

I keep the position under constant review and Welsh Government will continue to work in partnership with the Health Board and its staff to secure improvements. I will provide the necessary scrutiny, intervention and support to do what is right for the people of North Wales and ensure they receive the health services they deserve.

Yours sincerely,



Vaughan Gething AC/AM
Ysgrifennydd y Cabinet dros Iechyd a Gwasanaethau Cymdeithasol
Cabinet Secretary for Health and Social Services

Sutton, Elin (Staff Comisiwn y Cynulliad | Assembly Commission Staff)

From: Bethan Perkins <Bethan.Perkins@waleschc.org.uk>
Sent: 23 January 2019 14:38
To: Geoff Ryall-Harvey (CHC - NWCHC); Carol Williams (CHC - NWCHC)
Subject: Palliative Care during ward inspections

Hi Geoff and Carol,

I met with a complainant who was complaining about the palliative care her own mother received at Wrexham Maelor (MAU). The complainant is herself a palliative care nurse and she believes that most wards should be checked whether they have certain practices in place to help support these patients. I was wondering if something along the lines of these following questions are asked and if not, could be included in CHC ward inspections or could/should be passed on to the HB Ward Accreditation Team and included on their inspections?

- Do you have an End of Life Care box on the ward or an area where patient End of Life information is kept?
- Are there EOL information leaflets readily available for families i.e. what to expect when patients are dying, what facilities are available to them etc?
- Where is the EOL plan of care (Care decisions for the last days of life pathway) kept? Would expect the document to be held somewhere central.
- Is there an EOLC Facilitator or Dementia Nurse and can you provide their name?
- What do you have on the wards that recognises that patients are at EOL?
- Are systems in place to identify dementia patients (blue butterfly on the board above the bed)? Is there a similar system in place for EOL patients?
- Do you use a This is Me Document?

I would say that probably a quarter of my cases involve EOL concerns, that these patients and their families did not have a “good” EOL experience.

Secondly, I was at a meeting where a senior clinician on the above unit and he stated that they had the scan equipment but were having difficulties getting a sonographer up there(instead of patients having to go to a busy ultrasound department and wait with expectant mothers). The complainant offered to write a letter championing their cause, which he welcomed. We received no response from the letter. An email was sent to Gill Harris with the issue and she responded “The ultrasound scanner that is located on the Early Pregnancy Assessment Unit/Emergency Gynaecological Unit is used by medical staff to scan in emergency situations. All non-emergency scans will continue to be undertaken in the ultrasound department.” Which was rather a non-response to the reported issue of not being able to get it staffed. Do you ever do inspections of the Early Pregnancy Assessment Unit, if so are members in a position to check if and how often the ultrasound equipment is used there?

Thanks,
Bethan

BETHAN PERKINS
EIRIOLYDD CWYNION/COMPLAINTS ADVOCATE
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council.
Unedau 1B & 1D Parc Busnes Wilkinson, Ffordd De Clywedog, Ystad Ddiwydiannol Wrecsam, Wrecsam. LL13 9AE / Units 1B & 1D Wilkinson Business Park, Clywedog Road South, Wrexham Industrial Estate, Wrexham. LL13 9AE. Ffôn / Tel : 01978 356178 est/ext 2

Ysgrifennwch ataf yn Gymraeg neu Saesneg
Please write to me in Welsh or English

Os ydych angen yr wybodaeth yma ar ffurf wahanol cysylltwch â 01978 346873 est 106 neu bethan.perkins@waleschc.org.uk
If you need this information in an alternative format please contact 01978 346873 ext 106 or bethan.perkins@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

Sutton, Elin (Staff Comisiwn y Cynulliad | Assembly Commission Staff)

From: Debra Jones <Debra.Jones@waleschc.org.uk>
Sent: 10 January 2019 15:31
To: Carol Williams (CHC - NWCHC); Geoff Ryall-Harvey (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Cc: Debbie Postle (CHC - NWCHC); Allison Hughes (CHC - NWCHC); Lucy Barker; Bev Davies (CHC - NWCHC)
Subject: RE: Public Accounts Committee Inquiry - Tawel Fan

Hi Carol

These are some of the general themes that we feel are on-going and that we are aware of:

- Problems with support in the community- there appears to be a lack of care coordinators and those that are in post, don`t seem to be retained for long.
- Lack of continuity of care (some of it prob due to the above)
- Care plans not followed or not in place at all
- Appears to be no permanent psychiatrist in NYG
- Appears to be mainly locums in Hergest – once these move on patients left in limbo, new locums start with back log and OPDs pushed back with some patients waiting months to be seen
- Cancelled appointments
- Problems when trying to self-refer
- Community MH units seem to be a law unto themselves – don`t feel that anyone takes over arching responsibility. Management structure should be more visible, clearer and accountable.

Also, a recent complaint seemed to indicate that Bryn Y Neuadd was having difficulty with provisions – things not being replaced and delivery not reliable (i.e. butter, sugar, squash and soap powder).

Regards

Debra, Audrey and Emily

DEBRA JONES
EIRIOLYDD CWYNION / COMPLAINTS ADVOCATE
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council
11 Llys Castan/Chestnut Court, Ffordd y Parc, Parc Menai, Bangor, Gwynedd, LL57 4FH
Ffôn/Tel 01248 679 284 est/ext 2

Rydym yn croesawu gohebiaeth trwy gyfrwng y Gymraeg a'r Saesneg. Os byddwch yn ysgrifennu atom yn Gymraeg byddwn yn ateb yn Gymraeg, ni fydd hyn yn arwain at oedi wrth ymateb i'ch gohebiaeth
We welcome correspondence through the medium of both Welsh and English. If you write to us in Welsh we will answer in Welsh, this will not lead to a delay in responding to your correspondence

Os ydych angen yr wybodaeth yma ar ffurf wahanol cysylltwch â 01248 679284 est 2 neu debra.jones@waleschc.org.uk

If you need this information in an alternative format please contact 01248 679284 ext 2 or debra.jones@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

From: Carol Williams (CHC - NWCHC)
Sent: 09 January 2019 15:59
To: Debra Jones; Geoff Ryall-Harvey (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Cc: Debbie Postle (CHC - NWCHC); Allison Hughes (CHC - NWCHC); Lucy Barker; Bev Davies (CHC - NWCHC)
Subject: RE: Public Accounts Committee Inquiry - Tawel Fan

Great stuff – many thanks all

C

CAROL WILLIAMS
DIRPRWY BRIF SWYDDOG / DEPUTY CHIEF OFFICER
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council
11 Llys Castan/Chestnut Court, Ffordd y Parc, Parc Menai, Bangor, Gwynedd, LL57 4FH
Ffôn/Tel 01248 679 284 est/ext 3

Ysgrifennwch ataf yn Gymraeg neu Saesneg
Please write to me in Welsh or English

Rydym yn croesawu gohebiaeth trwy gyfrwng y Cymraeg a'r Saesneg. Os byddwch yn ysgrifennu atom yn Gymraeg, byddwn yn ateb yn Gymraeg. Ni fydd hyn yn arwain at oedi wrth ymateb i'ch gohebiaeth.
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Os ydych angen yr wybodaeth yma ar ffurf wahanol cysylltwch â 01248 679284 est 3 neu carol.williams@waleschc.org.uk
If you need this information in an alternative format please contact 01248 679284 ext 3 or carol.williams@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
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From: Debra Jones
Sent: 09 January 2019 15:56

To: Carol Williams (CHC - NWCHC); Geoff Ryall-Harvey (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Cc: Debbie Postle (CHC - NWCHC); Allison Hughes (CHC - NWCHC); Lucy Barker; Bev Davies (CHC - NWCHC)
Subject: RE: Public Accounts Committee Inquiry - Tawel Fan

Hi Carol

We do seem to have some general themes, so we`ll pull something together tomorrow and get back to you.

regards

DEBRA JONES
EIRIOLYDD CWYNION / COMPLAINTS ADVOCATE
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council
11 Llys Castan/Chestnut Court, Ffordd y Parc, Parc Menai, Bangor, Gwynedd, LL57 4FH
Ffôn/Tel 01248 679 284 est/ext 2

From: Carol Williams (CHC - NWCHC)
Sent: 09 January 2019 14:22
To: Geoff Ryall-Harvey (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Debra Jones; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Subject: RE: Public Accounts Committee Inquiry - Tawel Fan

Hi all

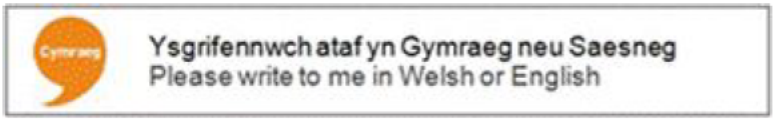
Further to Geoff's e-mail, we are particularly interested to hear about failings in BCUHB Mental Health Services since May 2018.

Should you have any examples, please can you provide us with the details.

Thanks

Carol

CAROL WILLIAMS
DIRPRWY BRIF SWYDDOG / DEPUTY CHIEF OFFICER
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council
11 Llys Castan/Chestnut Court, Ffordd y Parc, Parc Menai, Bangor, Gwynedd, LL57 4FH
Ffôn/Tel 01248 679 284 est/ext 3



Rydym yn croesawu gohebiaeth trwy gyfrwng y Cymraeg a'r Saesneg. Os byddwch yn ysgrifennu atom yn Gymraeg, byddwn yn ateb yn Gymraeg. Ni fydd hyn yn arwain at oedi wrth ymateb i'ch gohebiaeth.
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If you need this information in an alternative format please contact 01248 679284 ext 3 or carol.williams@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

From: Geoff Ryall-Harvey (CHC - NWCHC)
Sent: 09 January 2019 14:12
To: Carol Williams (CHC - NWCHC); Sue Irlam (CHC - NWCHC); Audrey Hughes (CHC - NWCHC); Bethan Perkins; Debra Jones; Emily Bowen (CHC - NWCHC); Ross Duffield (CHC - NWCHC)
Subject: Public Accounts Committee Inquiry - Tawel Fan

Dear All

I have been invited to give evidence to the Public Accounts Committee on 4th February. I am allowed to be accompanied by two CHC colleagues. Let me know if you would wish (*and be able*) to attend.

Regards

GEOFF RYALL-HARVEY
PRIF SWYDDOG / CHIEF OFFICER
Cyngor Iechyd Cymuned Gogledd Cymru / North Wales Community Health Council.

Unedau 1B & 1D Parc Busnes Wilkinson, Ffordd De Clywedog, Ystad Ddiwydiannol Wrecsam, Wrecsam. LL13 9AE / Units 1B & 1D Wilkinson Business Park, Clywedog Road South, Wrexham Industrial Estate, Wrexham. LL13 9AE.

Ffôn / Tel : 01978 356178 est/ext 3
07970 194777

Ysgrifennwch ataf yn Gymraeg neu Saesneg
Please write to me in Welsh or English

Os ydych angen yr wybodaeth yma ar ffurf wahanol cysylltwch â 01978 356178 est 3 neu geoff.ryall-harvey@waleschc.org.uk
If you need this information in an alternative format please contact 01978 356178 ext 3 or geoff.ryall-harvey@waleschc.org.uk

Sylwer y gellid mynnu, o dan delerau Deddf Rhyddid Gwybodaeth 2000, bod y Cynghorau Iechyd Cymuned yn gwneud cynnwys unrhyw e-bost neu ohebiaeth a dderbyniwyd yn gyhoeddus.
Please be aware that, under the terms of the Freedom of Information Act 2000, Community Health Councils may be required to make public the content of any emails or correspondence received.

Quality Safety & Experience Committee **22.1.19**	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board ***To improve health and provide excellent care***

Report Title:	HASCAS independent investigation and Ockenden governance review: progress report
Report Author:	Mrs Deborah Carter, Associate Director Quality Assurance
Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery
Public or In Committee	Public
Purpose of Report:	The paper provides the progress updates as at the end of Q3 against the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review
Approval / Scrutiny Route Prior to Presentation:	The Improvement Group and Stakeholder Group meetings review, monitor and scrutinise the work and progress of the recommendations
Governance issues / risks:	Work is underway to identify any additional resources required to progress the work identified to deliver improvements and address the recommendations.
Financial Implications:	A paper will be submitted to Executive Team setting out the additional resources and any related costings, including any additional workforce requirements, for their approval.
Recommendation:	To note the progress of the HASCAS & Ockenden recommendations

Health Board's Well-being Objectives *(indicate how this paper proposes alignment with the Health Board's Well Being objectives. Tick all that apply and expand within main report)*	√	**WFGA Sustainable Development Principle** *(Indicate how the paper/proposal has embedded and prioritised the sustainable development principle in its development. Describe how within the main body of the report or if not indicate the reasons for this.)*	√
1.To improve physical, emotional and mental health and well-being for all	√	1.Balancing short term need with long term planning for the future	√
2.To target our resources to those with the greatest needs and reduce inequalities	√	2.Working together with other partners to deliver objectives	√
3.To support children to have the best start in life		3. Involving those with an interest and seeking their views	√

4.To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being	√	4.Putting resources into preventing problems occurring or getting worse	√
5.To improve the safety and quality of all services	√	5.Considering impact on all well-being goals together and on other bodies	√
6.To respect people and their dignity	√		
7.To listen to people and learn from their experiences	√		
Special Measures Improvement Framework Theme/Expectation addressed by this paper Mental Health Leadership and Governance			
Equality Impact Assessment			

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

HASCAS Investigation and Ockenden Governance Review Progress Report as at January 2019

Background

In the autumn and winter of 2013 a series of events occurred which brought issues of concern regarding care on Tawel Fan Ward to the attention of senior staff within the Health Board. This led to the ward being closed in December 2013.

In January 2014, Donna Ockenden was commissioned by the Health Board to conduct an external investigation into the concerns raised and her report was published in May 2015.
http://www.wales.nhs.uk/sitesplus/documents/861/tawel_fan_ward_ockenden_internet.pdf

In August 2015 the Health Board commissioned an Independent Investigation to be undertaken by HASCAS Consultancy Limited into the care and treatment which had been provided on Tawel Fan Ward. The outcome of the Independent Investigation was the provision of three separate outputs which included:

- A thematic "Lessons for Learning" report
- Detailed Individual Patient reports to support the Putting Things Right process
- Individual Staff reports to support employment processes

The conclusions and findings of the thematic lessons for learning report were published in the '*Independent Investigation into the Care and Treatment provided on Tawel Fan Ward: A Lessons for Learning Report* 'on the 3rd May 2018 and included 15 recommendations. The full report and executive summary can be found via the following links:-

http://www.wales.nhs.uk/sitesplus/861/page/75258/
http://www.wales.nhs.uk/sitesplus/861/page/94107

Alongside the HASCAS investigation, a governance review was commissioned by the Health Board which was undertaken by Donna Ockenden. This review focussed on the governance arrangements relating to the care of patients on Tawel Fan Ward prior to its closure and current governance arrangements in older people's mental health services within the Health Board. The findings of the Ockenden Governance Review were received at the public Board meeting on 12th July 2018.
http://www.wales.nhs.uk/sitesplus/861/page/75258

On the 12th July at its public Board meeting, the Health Board considered a paper which contained the initial response to the HASCAS report and approved the governance and reporting arrangements which would oversee the implementation of the recommendations from the HASCAS report and the Ockenden Governance review. At this meeting the Health Board also approved the establishment and terms of reference for an Improvement Group to respond to the recommendations arising from both HASCAS and Ockenden reports as well as a Stakeholder Group to strengthen and guide the work of the Improvement Group.

Both the Improvement Group and the Stakeholder Group have now been established with membership agreed and confirmed in line with the respective terms of reference for both groups (attached at Appendix 1).

The inaugural meeting of the Improvement Group was held on 16th August 2018, and chaired by the Executive Director of Nursing & Midwifery, where the Group received status and progress updates from each of the operational leads who had been given delegated responsibility for specific recommendations. This included developing metrics and achieving milestones where these had been set in the reports as well as agreeing ones for where they had not. The leads also described progress towards achieving the outcomes of the recommendations. The second meeting of the Improvement Group was held on 23rd October and meetings are scheduled bimonthly throughout 2019 where progress reports are presented by each operational lead as well as monthly highlight reports submitted to the Executive Director of Nursing & Midwifery and an internal tracker tool developed for performance monitoring purposes.

The Stakeholder Group, which is a subgroup of the Improvement Group, has confirmed membership from representatives of the Community Health Council, Bangor University, St Kentigern Hospice, North Wales Police, North Wales Local Authorities, Community Voluntary Councils, North Wales Adult Safeguarding Board and Care Forum Wales as well as 6 Tawel Fan family members. The first meeting of the stakeholder group was held on Monday 8th October and was conducted in the form of a workshop, facilitated by the Associate Director of Quality Assurance and the Director of Partnerships for Mental Health & Learning Disabilities. The workshop aimed to engage with the members to:

- Establish Group Values
- Agree required outcomes
- Consider a 12 month forward view in the form of a work programme
- Establish individual areas of interest and intent to support

The group also reviewed the terms of reference for the group in order to consider their role in respect of scrutiny, advice, support, challenge and endorsement of the work being undertaken to deliver the required improvements. Members of the psychology service were also in attendance at the meeting to offer support to members if required.

The Stakeholder Group is required to meet quarterly, however, at the request of the members at the first meeting, an additional meeting was scheduled within 6 weeks, due to discussions around the amount of work and pace of progress, within a schedule of meetings being held on a quarterly basis. This second meeting was subsequently held on 19th November and enabled discussion and review of a proposed cycle of business for the work of each recommendation. Stakeholder Group members have also put themselves forward as members of any task and finish groups that have been established for specific recommendations, where they hold a particular interest and wish to contribute and support ensuring the views of stakeholders are incorporated into this important programme of work. Meeting dates have been scheduled quarterly throughout 2019.

On 1st November 2018, the Health Board received a paper providing an update against the recommendations of both the HASCAS and Ockenden recommendations as well

as confirmation of the establishment of both the Improvement Group and Stakeholder Group. The update presented by the Executive Director of Nursing & Midwifery reported positive progress following establishment of both the Improvement Group and Stakeholder Group. A piece of work was now being undertaken to review overall costs and required resources with the support of workforce and finance teams for consideration by the Executive Team.

Early positive feedback had been received from third sector representatives who had attended the first Stakeholder Group event and assurance was provided that the Health Board has been reviewing and strengthening its approach to partnership working and relationships with local authorities were also being maintained. In particular, the membership of the Regional Partnership Board has been strengthened and an event was held in January 2019 to share strategic issues and identify principles for improved collaboration. Further work is also underway to build further on relationships with the sector, with discussions taking place with third sector leaders and through the Health Board's Stakeholder Reference Group. This work is taking place alongside the development of the Health Board's three year plan and identification of priorities for 2019 onwards.

All recommendations from both the HASCAS and the Ockenden reports have been mapped together to ensure the necessary actions identified are embedded across the organisation and are not dealt with in isolation.

Table 1 below summarises the recommendations from both reports and sets out the blended governance and oversight arrangements.

This report provides updates against the recommendations as at the end of quarter 3, December 2018 and further progress updates will be reported to future board meetings no less than quarterly.

Table 1

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
1. Care Pathway and Service Redesign	**1**.Review and redesign service model for older people and those with Dementia **12.** Older Persons Strategy	Executive Director of Strategy	Deputy Director of Nursing	Older Persons Group / Regional Partnership Board.
2. Dementia Strategy	**8.** Dementia Strategy	Executive Director of Nursing & Midwifery	Area Director for Clinical Services (West)	Dementia Clinical Network Group
3. Care Homes and Service Integration		Executive Director of Nursing & Midwifery	Deputy Director of Nursing	Older Persons Group / Regional Partnership Board
4. Safeguarding Training		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
5. Safeguarding Informatics and Documentation		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
6. Safeguarding Policies and Procedures		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
7. Tracking of Adults at Risk across North Wales		Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
8. Evaluation of Revised Safeguarding Structures	**6**. Safeguarding structures	Executive Director of Nursing & Midwifery	Assistant Director Safeguarding	Corporate Safeguarding Group
9. Clinical Records		Executive Medical Director	Chief Information Officer	Health Records Group
10. Prescribing and Monitoring of Anti-Psychotic Medication		Executive Medical Director	Chief Pharmacist	Safer Medication Group
11. Evidence Based Practice	**2a.** Quality impact assessment **2b.** Integrated reporting **3**. Policy review **10.** Reviewing external reviews **14.** Board development	Executive Director of Nursing & Midwifery	Deputy Board Secretary	Quality and Safety Group
12. Deprivation of Liberties	**9.** Deprivation of Liberties	Executive Director of Nursing & Midwifery	Assistant Director, Safeguarding	Corporate Safeguarding Group
13. Restrictive Practice Guidance		Executive Director of Workforce & OD	Director of Nursing (Mental Health)	Quality and Safety Group (Corporate)
14. Care Advance Directives		Executive Medical Director	Senior Associate Medical Director	Palliative Care Group

HASCAS	Ockenden	Executive Sponsor	Operational Lead	Oversight Group
15. End of Life Care Environments		Executive Medical Director	Senior Associate Medical Director	Palliative Care Group
	2c. Workforce development **4a.** Staff engagement **4b. & 4c.** Staff surveys **4d.** Clinical engagement **13.** Culture change	Executive Director Workforce and Organisational Development	Head of Organisational and Employee Development	Workforce Senior Leadership Team / Staff Engagement Group
	2d. Consultant Nurse in Dementia	Executive Director of Nursing & Midwifery	Director of Nursing Mental Health	N/A
	5. Partnership working	Director Mental Health and Learning Disability	Director of Partnership Mental Health and Learning Disability	Together for Mental Health Partnership Board
	7. Concerns management	Executive Director of Nursing & Midwifery	Associate Director Quality Assurance	Quality and Safety Group
	11. Estates Older Persons Mental Health (OPMH)	Executive Director of Finance	Director of Estates and Facilities	Task Group

Recommendations updates

The following updates are provided against each of the recommendations in order of the sequence of the mapping described in Table 1:

HASCAS 1: Care Pathway & Service Redesign
HASCAS 3: Care Homes and Service Integration
Ockenden 1: Review & Redesign service model for older people and those with dementia [progress update required by end of Sept]
Ockenden 12: Older Persons Strategy

Three emerging themes have been identified for the above recommendations:
i) Organisational culture; including corporate & clinical governance and stakeholder relationships
ii) Strategy & planning; care pathways, service redesign for Older Persons Mental Health (OPMH) and care homes & service integration
iii) Organisational learning; including knowledge & skills, training & development and information management

Work has progressed to identify the interdependencies of the older person strategy alongside recommendations 2, 3 and 5 and a programme and scoping exercise has now been completed that includes the identification of all existing strategies currently in place. This initial scoping exercise has helped inform the Health Board's HASCAS & Ockenden delivery plan, the objective of which is to support the overarching integrated pathways for older persons and those with dementia. This will ensure that there is a focus on clinical redesign and integration, education and the integration with the care home sector.

An exercise has also been completed to scope out all interlinking Older Persons forums and groups to ensure consultation and engagement take place across the organisation. The Quality Safety Group meeting in January received an update on the end of life care pathway for Older Persons Mental Health and approved the draft Standard Operating Procedures presented to the group 'End of Life Care for the Person with Dementia under the care of In-patient Mental Health Services', ('*One chance to get it right'*).

Extensive work has been undertaken within BCUHB and the North Wales Regional Partnership Board in relation to care services across North Wales for the older person. In February 2019, a partnership event will be held, which will identify and review the significant work underway in both health and social care services, in addition to the care provider sector. This work will inform a gap analysis to aid the future delivery plan.

Joint working has also commenced with the Older Persons Commissioner for Wales' office and support gained to help advise on future delivery plans.

A North Wales training programme for 'Care of the Older Person and those with Dementia' has been developed in specific relation to knowledge and skills around the care of the elderly. This involves a basic module to be made mandatory to be accessible to all health and social care staff, care providers and families and will

ensure consistent delivery of training material for all services that deliver care to the older person. Furthermore, an advanced programme will be developed with Glyndwr and Bangor universities, for postgraduates.

A North Wales wide joint clinical event for BCUHB and Care Home staff will be held in the beginning of Quarter 4, for ward staff and care home managers, to capture shared experiences and learning; encourage team building; and most importantly improve relationships and communication across all acute, community and care home settings. Furthermore, this will help identify the work needed to improve clinical pathways for integration and the future development of a long term clinical strategy.

A 'Pledge of Principles' has been developed by a small partnership working group to raise awareness around the good practice principles of cross-sector working, which aim to refresh and raise awareness about the care philosophy that underpins staff culture and effective ways of working in true collaboration.

A delivery plan on the Health Boards support into North Wales Care Homes has been developed following the HIW report and a meeting is scheduled for January 2019 to discuss the implementation and outcomes to help inform the future delivery plan and long term clinical strategy.

Risks and Issues

- A joint and clear action plan with milestones and timelines is in place to mitigate risk to delivery of outcomes, particularly given the review of a broad range of services across the Health Board within required timescale.
- An agreed partnership approach will be taken when reviewing services to ensure validation of data between NHS reporting and local authorities.
- Joint responsibility will be undertaken in ensuring translation of strategy into action in response to workforce capacity and resource for transformation to avoid duplication and conflicting agendas.
- An agreed set of principles will be developed in partnership together with quality and safety standards to inform the model of care and strategy to ensure sustainability and differing standards of quality & safety of services across multiagency providers and commissioners of care.

HASCAS 2 & Ockenden 2: Dementia Strategy

The Health Board's Dementia strategy was co-launched in February 2018 by the Executive Director of Nursing & Midwifery and the Regional Director for Alzheimer's Cymru. The strategy emphasises the importance of how best to support individuals within their environments, whether this be at home or within a healthcare setting. A draft high level action plan has been developed and is being reviewed including the financial details required around some of the delivery areas. The Health Board will be working within the framework of working towards becoming a dementia friendly organisation in line with the Alzheimer Society's dementia friendly communities programme. The three District General Hospitals, Emergency Departments, main Out-Patient Departments, Older Person's Mental Health services and Learning Disability services have project leads and action plans in place for this work. In December 2018 Ysbyty Gwynedd become the first acute hospital site in Wales to achieve Dementia Friendly status.

A task and finish group responding to Recommendation 2 has been established and terms of reference agreed. The remit of this group is to support the development of the action plan and monitor the delivery of the priorities and objectives defined within the HASCAS report. The first two meetings have taken place in November and December 2018, with project support identified to progress the action plan.

HASCAS 13: Restrictive Practice Guidance

Relevant guidance has been reviewed by the operational lead and the Improvement Group have acknowledged that there was more recent and up to date NICE guidance (NG10, 2015) than that referred to in part 2 of Recommendation 13 (RCP, March 2007). This has been considered alongside the updated Mental Health Code of Practice and quality standards on how to support and assess people with dementia and how to manage behaviours which challenge.

The Task & Finish Group for Recommendation 13 has been very well represented from all areas of the Health Board and output from the group has enabled us to deliver a number of complex issues at pace. Terms of Reference for Recommendation 13 Task & Finish Group have been refreshed and revisited to ensure focus on the HASCAS recommendation and provide assurance, that all older adults and those with dementia, receive lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within BCUHB.

The Health Board Area Directors and Secondary Care Nurse Directors have undertaken a scoping exercise for restraint training and reviewed the scoping of restraint reporting. The Health Board's Restrictive Physical Intervention (RPI) policy has been ratified at the Policy Approval Group and Quality, Safety & Executive committee.

A benchmarking exercise has been undertaken across all areas against the policy implementation and the outcomes of this will be presented to Quality & Safety Group in January 2019.

A Proactive Reduction & Therapeutic Management of Behaviours which Challenge Policy has also been developed to support the delivery of Recommendation 13 and monitoring actions are in place to ensure it is achieved.

The requirement for a project management post has been submitted to lead on education, training and embedding positive management of behaviours to support the current programme of all Wales training passport modules A-C.

Identified processes are in place for patients within acute physical healthcare settings and who are distressed, due to a deterioration in mental health issues / symptomology, who will be assessed by liaison psychiatry and supported by MH&LD violence & aggression team.

Reporting of restraint incidents is being uniformed across the organisation utilising Datix as the reporting mechanism, training is being delivered to compliment a consistent approach of reporting, across the Health Board.

Ockenden 2d: Consultant Nurse in Dementia

The additional Consultant Nurse with a special interest in Dementia post has been advertised and interviews are scheduled for the 15th January 2019. The aim is to have a representative of the Stakeholder Group as part of the panel. Recruitment to this post is an essential step in response to the recommendations.

The Health Board are also working with Bangor University to review other roles including Advanced Nurse Practitioners to support people in their own homes.

HASCAS 4: Safeguarding Training
HASCAS 5: Safeguarding Informatics and Documentation
HASCAS 6: Safeguarding Policies & Procedures
HASCAS 7: Tracking of Adults at Risk across North Wales
HASCAS 8: Evaluation of Revised Safeguarding Structures
Ockenden 6: Safeguarding Structures
HASCAS 12 & Ockenden 9: Deprivation of Liberties

Following a scoping exercise across the whole of the safeguarding portfolio over the last 2 years, a thematic report and action plan including benchmarking are now in place. A further review has been undertaken of the Safeguarding Governance & Performance Group including membership to ensure the Terms of Reference enable the delivery and accountability of the HASCAS and Ockenden recommendations. A safeguarding dashboard has been developed and implemented and safeguarding has been included within the ward dashboards. Going forward a safeguarding communication strategy will be developed.

A scoping exercise has been undertaken of safeguarding policies and procedures and a matrix has been developed for monitoring, updating and implementation.

A Standard Operating Procedure (SOP) has been developed for adults at risk documentation, to support engagement, decision making and internal reporting and escalation. A revised and improved adult at risk reporting tool and database has been implemented.

Appointments have been made to several posts including Safeguarding Practice Development Lead, Safeguarding Data Analyst and a Business Manager.

All training packages have been reviewed and updated in line with legislation. A scoping exercise has been completed on training activity which has identified key areas of focus and the implementation of revised training packages and training methods.

A review has commenced of the Deprivation of Liberty (DoLs) service to identify and address the gaps in the service and ensure effective and efficient service delivery. Following the review, a position paper regarding the DoLs service and proposed requirements for the DoLs service and team will be presented at the Quality and Safety Group March 2019. A training package and governance framework has been developed for DoLs signatories this is to provide a monitoring framework of support, guidance and governance and to address the low numbers of signatories, relevant

staff are being identified for training, with a target of a minimum of 6 staff to be trained each month.

A new safeguarding web page has been developed with an implementation date of 21st January 2019 following which an external internet page will be developed for the public.

HASCAS 5: Safeguarding Informatics & Documentation
HASCAS 9: Clinical Records

Work has commenced in respect of training and communication in the use of safeguarding dividers within the clinical record and identified the need for a Standard Operating Procedure to be developed that will provide guidelines on filing and storing of safeguarding information to ensure consistency across all specialities. GRK training will be revised to include a section on filing of safeguarding information and uptake will be monitored by the Electronic Staff Record (ESR).

Significant work has commenced on the transfer of management of the Mental Health patient records within the same portfolio as acute patient records, under the Health Records service. The scope of this work has been expanded by the Executive Team of the Health Board in response to this and other regulatory recommendations (e.g. ICO Audit) to review the management arrangement for ensuring good record keeping across all patient record types including *Mental Health (inc. CAHMS, Drug and Alcohol services); Radiology, Audiology, Posture & Mobility Service (formerly ALAC), Sexual Health, Speech and Language Therapy, Community Hospitals, Child Health, Podiatry, Emergency Department, Physiotherapy, Occupational Health, Acute Records, Oncology, Midwifery, Genetics, Diabetics, Primary Prisoner Clinical Record*, all of which are now under the portfolio of the Executive Medical Director.

The 'Patient Records Transformation Programme' is being established with the Executive Medical Director as the Executive Lead and SRO, and will focus on 4 key areas of work; *ATHR under GDPR*, *Infected Blood Inquiry*, *Retention of Oncology Information within the Acute Record*, and the Project for this piece of work *'Management of BCU Patient Records'*

Phase 1 of this specific project will initially aim to deliver the following objectives of the overall programme to ensure:

- Objective 4: A baseline is in place that maps out the storage, processes, management arrangements and standards compliance, for all types of patient records, by (date).
- Objective 5: To present the recommendations and funding requirements to work towards PAN-BCUHB compliance with legislation and standards in patient records management across all case note types.

In order to progress this project which will meet the recommendations in both the HASCAS and Ockenden reports, and to ensure sustainability in mitigating against future risks, resource requirements to deliver this Programme have been identified and will be submitted for executive approval. Recognising that there will be many demands on limited resources; the Chief Information Officer is seeking to prioritise areas of

informatics funding to secure the senior 8b post required, however, funding for the Band 7 Project Manager will require additional funding.

HASCAS 10: Prescribing & Monitoring of Anti-Psychotic medication

The Health Board has recently updated guidance on prescribing antipsychotic medication in the presence of a dementia diagnosis (MM17) which will be subject following implementation, to a full audit within 12 months of the HASCAS report publication.

A medicines reconciliation audit was undertaken in Wrexham on the completion of an accurate drug history, within 24 hours of admission. This demonstrated that 24 hour targets are not consistently being met due to lack of pharmacy staffing on the OPMH wards, this can result in errors and omissions and the potential for patient harm. An improvement plan has therefore been developed which for the use of anti-psychotic medication, will mean that patients with a diagnosis of dementia will have 3 monthly reviews of any antipsychotic medication in use upon discharge.

A CAIR (checklist for antipsychotic initiation and review) chart has been prepared and distributed to all OPMH and CMHT teams across the MHLD Division (October 2018). Work is ongoing to continue to implement the use of the CAIR antipsychotic form and highlight best practice, particularly in care homes. The CAIR form and a letter has also been circulated to GPs and practice pharmacists for information.

Key to this work is the consistent availability of pharmacists or technicians on the wards and in CMHTs or memory clinics to support and embed change. This is being scoped and will be presented through the improvement group.

<u>Monitoring</u>

At present the pharmacy department is reviewing the capacity to support OPMH and care homes to deliver medicines optimisation in line with national recommendations and will report this back through the Improvement Group.

Care homes are not currently reporting on the use of anti-psychotics and length of treatment. In order to address this, a care home proforma is in development and will be progressed through the care home subgroup of the primary care pharmacists group. This will enable care homes which need support to be identified and targeted for intervention. In addition an all wales audit is being carried out in 2019 – 20 to identify the number of people with dementia who are prescribed antipsychotics.

The MHLD lead pharmacist for the Health Board will work with the Nurse Consultant in Dementia to ensure that training includes relevant information around psychotropic medication for frontline staff. A business case is being prepared to support a MDT project initiative. The anti-psychotic initiation and review (CAIR) chart will be used for people within the division and then rolled out across secondary care and community settings.

Also in line with the WG recommendations on antipsychotic prescribing, a project is being set up to trial the use of an ADRe (Adverse Drug Reaction profile) for use within

care homes / OPMH wards. This will aim to improve the documentation of care, side effects and monitoring, relevant to the use of all psychotropic drug usage. This has been implemented in Swansea where there was a notable reduction in falls as a result of the project.

Audit

Information is published annually in relation to the use of antipsychotics in care homes, benchmarked against NICE guidance and Welsh targets for patients with a diagnosis of dementia and this data was collected in primary care in 2017. The WG national audit of antipsychotic use in primary care is under consultation and is expected to deliver this recommendation once the audit implemented.

A community pharmacy care homes National Enhanced Services (NES) is in place to monitor antipsychotic use in care homes, to which only 5 pharmacies are currently signed up. Further work is ongoing to ensure all pharmacies that supply BCUHB care homes are signed up to the NES.

An audit of 'antipsychotics prescribing' including non-drug measures used to prevent behaviours that challenge is being planned jointly with the Consultant dementia nurse for February 2019 in line with HASCAS recommendations, and the National primary care audit on prescribing of antipsychotics in dementia is being planned for 2018-19 .

Implementation

A business case has is being prepared to fully support implementation and recommendations to increase pharmacy support to MHLD in order to support the full HASCAS recommendations including Recommendation 10.

HASCAS 11: Evidence Based Practice
Ockenden 2a: Quality Impact assessment
Ockenden 2b: Integrated reporting
Ockenden 3: Policy review
Ockenden 10: Reviewing external reviews
Ockenden 14: Board Development

The Board in September 2018 adopted revised arrangements for Board and Committee meeting arrangements to respond to the findings and recommendations of the Deloitte report into financial governance, the Wales Audit Office Structured Assessment for 2017, and the advice of the Specialist Adviser to the Board.

http://www.wales.nhs.uk/sitesplus/documents/861/Agenda%20bundle%20Board%20Public%206.9.18%20V2.0.pdf

The revised arrangements are intended to further improve and strengthen the effectiveness of the Governance Arrangements of the Board and its Committees, ensuring greater oversight and challenge in key areas by Independent Members and the ability for Executives to have an increased focus on turnaround and operational productivity. The revised arrangements seek to ensure appropriate time between meetings for follow up actions to be taken forward, whilst maintaining the ability to provide timely financial and performance reports to the Board and its Committees.

Failings in the health and social care systems in the past have highlighted the on-going need for greater focus on the impact on quality when considering cost improvement or efficiency related changes. A system is in place for Quality Impact Assessment (QIA) of savings schemes and progress will be measured from samples of completed QIAs and a record of outcomes and as part of the internal audit programme 2019/20. No changes, schemes, or indeed overall financial plans, will be approved without first having received appropriate assurances that the impact of the proposed changes on quality have been appropriately assessed and are, in the worst case neutral but at best are aiming for an improvement in quality. With an increased focus on cost containment and improving efficiency managers have been tasked with ensuring that any projects or schemes to help achieve this aim have due regard for the impact on service provision.

The Board has also sought to strengthen its decision making with a clear focus on quality and affordability and had revised its coversheet template to expressly include a requirement to document financial implications of any proposals. In addition, the Terms of Reference of the Finance and Performance Committee of the Board have been modified in this respect.

Following changes in the Executive portfolios and weaknesses identified in the effectiveness of the performance and accountability framework, the arrangements in place have been subject to detailed review. A revised framework has been considered by the Executive Management Team and was subsequently discussed at a Board Workshop in autumn 2018. The key principles set out in the revised framework include supporting the organization in delivering:

a) The strategy set out by the Board through the IMTP or Operational plan
b) Operational ownership of the key organizational priorities across services and at each level in the organization
c) Clarity of expectations as to level of performance expected within resources allocated to services
d) Decision-making based on visible performance information triangulated across key indicators
e) Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
f) Opportunity for accountable officers to discuss support needed to achieve expected levels of performance
g) Challenge to accountable officers through a holding to account mechanism for areas where performance falls below expectations.
h) Clarity as to outcomes and consequences of poor performance through clear escalation process

Revised arrangements have been agreed in principle and are being tested over the next six months to ensure that they provide a more robust and effective accountability mechanism.

Work has been underway for some months to review the Health Board's arrangements for managing BCU wide policies, procedures and other written control documents

(WCDs). Part of this has involved the review of the Policy on Policies together with a new intranet page. The revised policy and intranet page were launched in September 2018.

Numerous sessions have been held between October and December to ensure Directorate Governance Leads are fully conversant with the new policy and the transfer arrangements to the new intranet location. In order to avoid any confusion or risk, staff, particularly clinical staff not being able to access documents quickly (from their former locations) transition arrangements are in place. One to one meetings with the Leads have been taking place to confirm which documents can move across to the new site and from what date and to agree dedicated communication plans for various cohorts of policies in terms of the key target audience. Access to the documents from the old location will remain active for an initial period but these links will be withdrawn over time and substituted with redirection notices. Staff feedback on the new arrangements has been encouraged (agreement in terms of the timeline for transition leading to final arrangements will be agreed by the end of April 2019).

The new Policy on Policies appends a new template which also includes a table showing the approval route for various types of document. Staff have been reminded that all clinical policies should be developed using a person centred approach. Existing Policies are being reviewed to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified and if necessary separate clinical policies and procedures will be developed with input from experts. Authors of Policies, Procedures and other WCDs have also been reminded of the need to undertake an Equality Impact Assessment on all Health Board wide Policies and Procedures to ensure that decisions do not discriminate against people based on any protected characteristic. Environmental Impact Assessments also need to be undertaken where appropriate.

In relation of BCU wide clinical policies the Corporate Nursing Team have undertaken a clinical policies mapping exercise to determine the location and current status of all clinical policies. These clinical policies have been risk assessed in terms of prioritising those that require urgent review under the direction of the Executive Clinical Directors. In line with the existing policy on policies the Quality, Safety and Experience Committee of the Board must approve clinical policies. From August 2018 an additional step has been added to the ratification and approval process with all new or refreshed clinical polices being scrutinised by the Quality and Safety Group to ensure they are fit for purpose and are evidence based. In addition to this a BCU wide mapping exercise has been undertaken to assist Leads in identifying all linkages to existing intranet documentation supported by the Compliance Officer.

Reviewing External Reviews – Work has been undertaken to strengthen assurances around external reports produced in respect of the Health Board. The Corporate Nursing Team have undertaken a review of all HIW inspections from July 2017 to July 2018 to identify findings, recommendations and actions which were applicable to older people and specifically the care of older people with mental health concerns. All open/outstanding actions arising from these inspection reports continue to be monitored/managed on a monthly basis by the Quality and Safety Group. In addition to the review as detailed above, it should be noted that a BCUHB/HIW Management plan was ratified at the June 2018 Quality and Safety Group and has been circulated

to all Leads. This Management Plan has introduced the following additional assurance processes:

- Members of the Corporate Nursing Team complete regular post HIW inspection walkabouts (approximately six months post inspection) to review both closed and open/outstanding actions to identify areas of good practice, if actions/recommendations have been sustained and to offer support where required for open/outstanding actions;
- The Corporate Nursing Team hold regular meetings with Governance/Local Leads to progress action plans and review both open and outstanding actions to provide support where required, share learning and celebrate success.
- The Corporate Nursing Team to work with Governance Local Leads post inspection to ensure SMART action plans are developed in response to HIW inspection findings/recommendations.
- Pan BCUHB level actions (identified during local HIW inspections) are taken to the Quality and Safety Group for review and to identify/allocate a Lead.
- Thematic Analysis of HIW findings from 2015 to date has been undertaken by the Informatics Team to inform future improvement plans/learning.

The actions as outlined continue to be implemented in accordance with the agreed HIW Management Plan which can be accessed via the following link.
http://howis.wales.nhs.uk/sitesplus/861/page/74145

In addition to this the Office of the Board Secretary has established a database to capture all externally commissioned/produced reports such as the Delivery Unit, Royal Colleges, Commissioners etc. to ensure such reports are centrally logged and a lead officer identified. Further work is being undertaken to improve the system for recording external reports to ensure logging, cascade and follow up are automated as far as possible. Discussions have taken place with the All Wales Board Secretaries Group to share best practice. Resources in this area have also been strengthened with the assignment of a Compliance and Assurance Manager. These improvements will ensure that the system logging those reports is robust. This system has recently been expanded to capture applicable recommendations originating from National Assembly Wales (NAW) Committee Business. The relevant Committees are as follows:

- Children, Young People and Education Committee
- Climate Change, Environment and Rural Affairs Committee
- Committee for the Scrutiny of the First Minister
- Constitutional and Legislative Affairs Committee
- Culture, Welsh Language and Communications Committee
- Economy, Infrastructure and Skills Committee
- Equality, Local Government and Communities Committee
- External Affairs and Additional Legislation Committee
- Finance Committee
- Health Social Care and Sport Committee
- Petitions Committee
- Public Accounts Committee

NAW Committee business (agendas and minutes) is monitored by the Compliance and Assurance Manager. Items of note (Inquiries, Petitions, Reports, Recommendations, and Consultations) are logged and reviewed by the Office of the Board Secretary Senior Management Team. Where applicable, items are added to the TeamMate electronic monitoring system and reported via the Audit Committee.

In relation to Board Development, the Executive Director of Nursing and Midwifery has given consideration to Ockenden Recommendation 14 and has determined that this ambition will best be met by the full Board undertaking dementia training which will be delivered on 10.1.19 to be led by the Consultant Nurse (Dementia) and a Service User National Champion.

HASCAS 14: Care Advance Directives
HASCAS 15: End of Life Care Environments

Work is underway to embed and roll out Advanced Care Planning. Clarification has been sought with HASCAS that the ongoing work is for planning, not directives, as cited in the report.

In relation to Treatment Escalation Plans (TEPs) and DNACPR, significant progress has been made with increasing numbers of end of life conversations taking place within community and hospital settings. Communication with families is being encouraged to share decision making and identify common goals. Learning from the initial pilot of TEPs implementation in the community will inform further roll out.

The National Audit for Care at the End of Life (NACEL) The National Audit for Care at the End of Life (NACEL) was carried out nationally in 2018, and in BCUHB was led by the Performance Directorate. The North Wales Department for Specialist Palliative Care contributed to the data collection and the full audit of organisational data for end of life care in hospital settings, was submitted by the Performance Directorate; results awaited early 2019. The National Audit of Dementia (NAD), both audits have been added to the National Clinical Audit & Outcome Review Plan (NCAORP) Welsh Government programme of mandatory projects for 2018/19.is currently underway being led by Dr Andrew Shuler (Consultant in Palliative Medicine) and the National Audit of Dementia (NAD), both audits have been added to the National Clinical Audit & Outcome Review Plan (NCAORP) Welsh Government programme of mandatory projects for 2018/19.

In respect of End of Life Care environments, a task and finish group has been established and has met to determine the actions required. These have been developed further into a SOP to support delivery of high quality end of life care on Older Person's Mental Health Wards (OPMH) and training has commenced for Older Persons Mental Health (OPMH) nurses in respect of this guidance and SOP to improve the end of life care environment on OPMH wards. In addition a process is in place to monitor paperwork for inpatient deaths for patients receiving palliative & end of life care. This has been developed by the North Wales Department for Specialist Palliative Care to ensure a full complement of nursing staff are trained in this area and know how to access additional support from palliative care services. Staff training commenced in early December 2018 and a further six study days are being held

monthly (January – June 2019), in addition to staff from OPMH wards being able to access further training on a regular basis.

A dementia care pathway has been developed with the Alzheimer's Society.

Ockenden 2c: Workforce Development
Ockenden 4a: Staff engagement
Ockenden 4b & 4c Staff surveys
Ockenden 4d: Clinical engagement
Ockenden 13: Culture change

A draft Workforce Strategy is in place which details workforce improvements aligned to organisational priorities. Work has progressed in the following areas:

- The Team Survey element of the Go Engage tool which has been rebranded for the organisation as 'ByddwchYnFalch / BeProud' is being deployed to support the Older People care Pathway as a priority. Teams will commence training in engagement improvement work in March 2019, each team will produce a team level 6 month improvement plan supported by the Organisational Development Team.
- NHS Wales Staff Survey intelligence is being used to drill down into priority areas in order to develop meaningful team/department level improvement plans to support improved engagement, staff workplace experience and culture.

Ockenden 5: Partnership working

The Health Board recognise the importance of working effectively at a strategic level with the voluntary sector and wide range of multi-agency partners and is set out within the mental health strategy. Different ways of partnership working are being considered to develop, provide and sustain services to older people and those older people with mental health needs and dementia and a strategy implementation structure is in place. Local implementation teams are established with the third sector and including wider partner representation Engagement sessions have been held with third sector providers to develop themes and reports to ensure clear alignment to achievement of outcomes and objectives.

All mental health third sector contracts / grants for 2016/17 will be reviewed to inform strategy development in line with the dementia plan and the Health Board's *living healthy, staying well strategy* in relation to older people and older people with mental health needs. This will ensure a more diverse range of delivery models and fully implemented effective contract management arrangements.

A commissioning framework will be completed via the mental health commissioning group with a commissioning plan developed setting out clear intentions. A commissioning lead will be appointed within the agreed mental health structure.

Ockenden 7: Concerns Management

Work is progressing to improve the thematic analysis for management of concerns and the timescales for responses. Progress has been made with a 50% reduction in the total number of open complaints achieved with many legacy complaints now dealt

with, and improved responses, in real time. Reductions are also reported in the number of major and catastrophic incidents and the number of complaints that are open beyond 3 months.

Improvement plans have been developed for all elements of the service and task and finish groups have been established to drive improvement work. These will focus on:

- Staff training (including roles and responsibilities)
- Putting Things Right Management including Redress
- Data Analysis to include lessons learned and sharing
- Communication with and about patients including timeliness of responses, depth of investigations and letter writing
- Review of all policies and guidance to support the principles of good complaint and incident management

Work is ongoing to rollout the PASS (Patient Advocacy and Support Service) which has been piloted at Ysbyty Glan Clwyd to support increased local resolution of complaints in near or real time.

The roll out of an electronic form to support complainants to register and submit concerns has been commenced in January 2019.

A review of the Patient Experience real time data feedback is underway the results of which will be used to shape the way the service is offered.

Dashboards are in development to be used at a ward and department level which will include a broad range of patient experience measures including real time feedback, complaints and harms reported from incidents.

A revised process for claims has been completed and ratified at Quality & Safety Group. This process will be audited in March.

Ockenden 11: Estates – Older Persons Mental Health

A multi-directorate / professional task and finish group has been established with agreed terms of reference and membership which includes Operational Estates, Estate Development and Mental Health and Learning Disabilities to deliver the following work streams for initially Older Persons Mental Health Facilities and thereafter all ward areas within inpatient facilities.

Scoping exercise has been competed for work stream 1 to develop a site by site schedule (Inventory) of outstanding repairs and actions required from recent and previous external HIW and CHC audits and inspections relating to MH&LD OPMH facilities. Work is progressing to reduce the number of outstanding repairs required.

Work Stream 2 will develop the Kings Fund *Enhancing the Healing Environment* (EHE) assessment across all wards within MH&LD OPMH facilities to determine the scope of work and resources required at each facility.

Work Stream 3 will develop the Kings Fund *Enhancing the Healing Environment* (EHE) assessment across all remaining wards to determine the level of resources required. Scoping work has commenced on identifying outstanding repairs from within operational estates work management systems. Work has also commenced on identifying outstanding works and actions contained within previous and current HIW and CHC audits and inspections and a detailed schedule of work is being developed.

Project management capacity and availability of revenue and capital requirements are identified as required resources to support the delivery of the three work streams.

Appendix 1

Improvement Group (HASCAS and Ockenden)

Terms of Reference

1.1 The Health Board will establish under the direction of the Executive Director of Nursing and Midwifery an Improvement Group to oversee the implementation of the recommendations arising from the HASCAS Thematic Report a Lessons for Learning Report and the Ockenden Governance Review to be published July 2018.

1.2 The Improvement Group are responsible for ensuring that there is a clear plan to address the recommendations and will provide leadership, governance and scrutiny of the implementation of the recommendations adopting an improvement methodology to sustain change.

1.3 The Improvement Group will, on behalf of the Health Board, maintain a robust grip and oversight of the improvement work required. The Improvement Group will take decisions and make arrangements which need to be effected to respond to the recommendations and the Executive Director of Nursing and Midwifery will report on progress directly to the Quality, Safety & Experience Committee of the Health Board to provide assurance on progress, no less than 3 times a year.

1.4 It remains the responsibility of the Health Board to scrutinise the findings and recommendations of the HASCAS Lessons for Learning Report and the Ockenden Governance Review. When the recommendations have been implemented and improvements have been made to the satisfaction of the Quality, Safety, Experience Committee, the Improvement Group will be stood down.

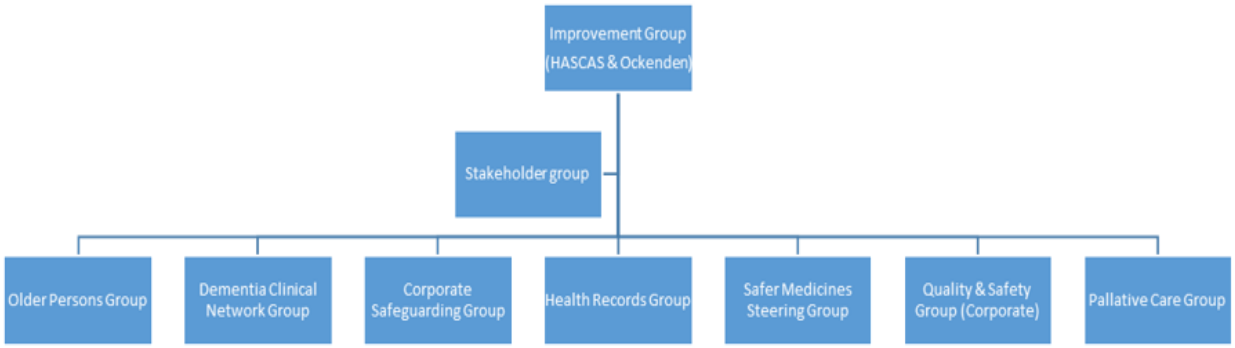
Remit

1.7 The Improvement Group in respect of its actions, provision of advice and assurance is authorised by the Board to;

- Ensure there is a clear plan to address the recommendations
- Scrutinise, challenge and seek assurance on the actions identified to effectively deliver the recommendations;
- Hold programme leads to account for the successful implementation of actions in response to the recommendations;
- Agree and monitor metrics in order to identify improvements and track progress against these;
- Agree direct actions to address any under-performance including the mitigation of risk;
- Provide assurance to the Board via Quality, Safety and Experience Committee of the progress being made, escalating as appropriate.

Improvement Group Structure

1.8 The Improvement Group governance and reporting structure is set out below:



Membership

Membership of the Improvement Group shall comprise of the following;

Executive Director of Nursing & Midwifery (Chair)
Executive Medical Director (Vice Chair)
Associate Director of Quality Assurance (Chair of Stakeholders Group)
Associate Board Member (Director of Social Services)
Executive Director of Workforce and Organisational development
Nurse Director Mental Health & Learning Disability
Medical Lead Older Persons
Named Doctor Adult Safeguarding

In attendance:
Welsh Government Advisor
Operational Leads for addressing the recommendations.

The Chair will have the discretion to invite additional members to the meeting if it becomes apparent that this is appropriate and necessary to fulfil the purpose of the group e.g. finance

Nominated deputies will be permitted

Meetings

Quorum

1.9 At least four members including one executive director must be present to ensure the quorum of the Improvement Group.

Frequency of meetings

1.10 Meetings shall be held no less than bi monthly or otherwise as the Chair of the Group deems necessary.

Agendas and Papers

1.11 The Improvement Group will be supported administratively by the office of the Executive Director of Nursing and Midwifery, whose duties in this respect will include;

- Chairing
- Dedicated secretariat
- Programme Manager
- Producing and collating assurance reports to the Quality, Safety and Experience Committee
- Maintaining oversight and monitoring progress on the implementation of the recommendations and work progress of the sub groups
- Arrangement of meetings

Reporting and Assurance Arrangements

1.12 The Improvement Group is accountable to the Quality, Safety & Experience Committee for its performance in exercising the functions as set out in these Terms of Reference.

1.13 The Improvement Group shall recognise the interdependencies of wider improvement work within the organisation, especially as it relates to dementia care and older person services.

1.14 The Improvement Group will:

- Provide an assurance report after each meeting normally bi monthly, outlining progress to date, a summary of the business discussed, key assurances provided, key risks identified including mitigating actions and milestones, matters which require escalating to the Quality, Safety & Experience Committee and planned business for the next meeting.

- Ensure appropriate escalation arrangements are in place to alert the Quality, Safety & Experience Committee to any urgent / critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

- Embed the Health Board's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

1.15 The Improvement Group has delegated authority from the Board and Quality, Safety & Experience Committee to exercise its functions as set out within these Terms of Reference.

Date Terms of Reference Approved:…….

Review date: August 2019

Stakeholders Group

Terms of Reference

The Health Board recognises the importance of Stakeholder engagement and wishes to establish a Stakeholder Group to strengthen and guide the work of the Improvement Group (HASCAS and Ockenden).

Remit

The group will provide scrutiny, advice, support, challenge and endorsement of the work being undertaken to deliver the necessary improvements across all areas affected by the recommendations from the HASCAS Thematic Review and the Ockenden Governance Review when published in July 2018.

The Stakeholder Group will provide a forum to facilitate full engagement and activate debate amongst stakeholders from across the communities served by the Health Board. Their aim will be to reach and present, wherever possible, a cohesive and balanced stakeholder perspective to inform the Improvement Group's decision-making in relation to implementing the recommendations arising from the HASCAS Thematic Review and the Ockenden Governance Review.

Membership

Membership of the Stakeholder Group shall comprise of the following;

Associate Director of Quality Assurance (Chair)
Director of Mental Health and Learning Disabilities (Vice Chair)
Representative of North Wales Local Authorities
Representative of Community Health Council
Representative of Bangor University
Representative of the Community Voluntary Councils
Representative of North Wales Police
Representative of Tawel Fan families (x5)
Representative of service user families and carers
Representative of Care Forum Wales.

The Chair will have the discretion to invite additional members to the meeting if it becomes apparent that this is appropriate and necessary to fulfil the purpose of the group.

Meetings

Quorum

1.16 At least one Health Board management member and three stakeholder members must be present to ensure the quorum of the Stakeholder Group.

Frequency of meetings

1.17 Meetings shall be held no less than quarterly and otherwise as the Chair of the stakeholder Group deems necessary.

Agendas and Papers

1.18 The Stakeholder Group will be supported administratively by the office of the Executive Director of Nursing and Midwifery, through the Associate Director for Quality Assurance whose duties in this respect will include;

- Chairing
- Dedicated secretariat
- Arrangement of meetings
- Ensure strong links to communities
- Facilitate effective reporting to the Improvement Group thereby enabling the Quality, Safety and Experience Committee to gain assurance that the business of the Stakeholder Group accords with the governance and operating framework set.

Reporting and Assurance Arrangements

1.19 The Stakeholder Group is accountable to the Improvement Group (HASCAS and Ockenden) for its performance in exercising the functions as set out in these Terms of Reference.

1.20 The Stakeholder Group shall recognise the interdependencies of wider improvement work within the organisation especially in older person and dementia services.

1.21 The Stakeholder Group will:

- Report formally after each meeting on the activities of the Group outlining progress to date and key recommendations and advice made to the Improvement Group.

- Embed the Health Board's vision, standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

The Stakeholder Group has delegated authority from the Improvement Group to exercise its functions as set out within these Terms of Reference. Through its Chair and members it shall work closely with the Improvement Group to co-ordinate the sharing of information and good governance ensuring that its outputs are aligned with the Health Board's strategic goals.

Date Terms of Reference Approved:…….

Review date: August 2019

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
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1st August 2018

Gill Harris
Director of Nursing
Betsi Cadwaladr UHB
BY EMAIL ONLY

Dear Gill

PTR PROCEDURES

Recent discussions with my Advocacy Team have left me concerned about a developing practice within your Concerns Team. This is that complainants are invited to a meeting with key staff to discuss their concerns and at the close of the meeting are informed they will be sent a recording of the meeting and a written summary. Complainants are usually not told that the matter is being dealt with outside of PTR. ***The meeting is presented as the full and final response of BCUHB, the case is closed at that point because it has been downgraded to an "on the spot" matter.***

When this process has been followed the complainant suffers a number of disadvantages;

- Complainants are told the case is closed and if there are any further issues they must be raised as new and separate complaints;
- The report of the meeting and any action is no longer subject to Executive scrutiny because it is signed off by Patient Experience leads;
- Complainants are not told of their right to go to the PSOW or the time limits set by the PSOW;

- Issues of breach of duty, qualifying liability and harm is not referred to in the meeting summary;
- Complainants may be inappropriately denied access to PTR and Redress if they are unaware of NHS Concerns Procedures (*this applies particularly to individuals who are not supported by the CHC*);
- It is our experience that complainants are asked if they are satisfied and given little or no explanation of other options that might be available to them;
- It is claimed that complainants are being told that their concern is being dealt with outside the PTR procedures but this is not our experience. Often complainants do not know or understand what the various components of the complaints procedures are not able to give informed consent to the route they are being taken down and do not understand the disadvantages;
- We are informed that if Concerns Team members feel that there has been no breach of duty, qualifying liability or harm then they can decide to downgrade the matter to an "*on the spot*", informal status.

We do not wish to unnecessarily delay resolution and would generally regard any steps to deal with complaints more speedily as a good thing. However, this cannot be at the cost of disadvantaging complainants or losing the value of complaints in monitoring standards and ensuring best practice.

I wonder whether it would be possible for us to meet to discuss the issues that these new practices present and ensure that the correct balance between speed and accountability is maintained.

Regards

Geoff Ryall-Harvey
Chief Officer

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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Dyddiad / Date: 9 August 2018

Dear Geoff

Thank you for your recent letter dated 1st August 2018 regarding PTR procedures, it is always helpful to receive feedback to enable us to review our practices and where we can make improvements.

In considering your comments I have reviewed with the team our overall approach to complaints handling and it is clear that the Health Board has indeed been increasingly offering meetings to complainants in an effort to offer more timely resolution to their concerns. This approach is only applied for complaints where there is no allegation of harm. Such complaints are logged as an 'on the spot' (OTS) and are passed to the relevant division for local resolution. The divisional staff contact the complainant within 2 days of receiving the complaint and attempt to resolve the issues to the complainant's satisfaction. Should this be successful the complaint will be closed as an OTS. Should the complainant remain dissatisfied or request the complaint be managed formally, the complaint will be managed under PTR and appropriately investigated.

These cases are managed within the agreed timescale of 'ideally the next working day'. Should this not be deliverable the complaint will be made formal and responded to under PTR. However, in some cases particularly where a meeting is planned within the agreed timescale but cannot happen due to availability of relevant people (to include the complainant), with the complainants agreement the OTS may be open longer than the recommended timescale. This approach does not preclude a written response confirming the actions taken.

This approach is in keeping with the PTR regulations for managing OTS. I understand that Barbara Jackson met with your advocacy team early in the early days of this approach to discuss the benefits and any potential concerns. There was broad agreement with this approach as being better for the complainants.
In terms of your specific issues raised:

- Complainants are told the case is closed and if there are any further issues they must be raised as new and separate complaints;

The OTS should not be closed unless the complainant is satisfied with the outcome. If they have further issues to raise after the closure has been agreed these would indeed be a new complaint as would be the case had it been dealt with as a formal complaint.

- The report of the meeting and any action is no longer subject to Executive scrutiny because it is signed off by Patient Experience leads;

Only cases where there is no allegation of harm would be dealt with as an OTS. These are managed by the relevant division and the relevant senior managers in that service are sighted on these. There is regular reporting of the themes and trends for cases dealt with as OTS at Board level.

- Complainants are not told of their right to go to the PSOW or the time limits set by the PSOW;

The management of OTS cases is laid out in the regulation for PTR and allows for these type of complaints to be managed outside of PTR. No OTS would be closed unless the complainant was satisfied with the outcome. Should they become dissatisfied on reflection we would advise them that we would make their complaint formal and investigate under PTR. Their right to approach the Ombudsman would then be advised in the PTR response. The PSOW will not routinely investigate until the PTR process has been exhausted.

- Issues of breach of duty, qualifying liability and harm is not referred to in the meeting summary;

A complaint where there was an allegation of harm would not be dealt with as an OTS. Should there be an indication during the management of the OTS that harm may have been caused, this would become a formal complaint and be managed under PTR.

- Complainants may be inappropriately denied access to PTR and Redress if they are unaware of NHS Concerns Procedures (*this applies particularly to individuals who are not supported by the CHC*);

This approach is only used for complaints where there is no allegation of harm.

- It is our experience that complainants are asked if they are satisfied and given little or no explanation of other options that might be available to them;

We are clear that OTS should not be closed until the complainant is satisfied with the outcome. If you have cases where this has not happened I would be very grateful if you could share examples of these so that I can review them.

- It is claimed that complainants are being told that their concern is being dealt with outside the PTR procedures but this is not our experience. Often complainants do not know or understand what the various components of the complaints procedures are not able to give informed consent to the route they are being taken down and do not understand the disadvantages;

Again if you could make me aware of these cases I would welcome the opportunity to review them.

- We are informed that if Concerns Team members feel that there has been no breach of duty, qualifying liability or harm then they can decide to downgrade the matter to an "*on the spot*", informal status.

If there is no allegation of harm, and there can be a quick response for the complainant that they are satisfied with, then it is possible to resolve the case for the complainant as an OTS.

I would like to assure you that we aim at all times to ensure that the processes operating within the Health Board are in line with the PTR guidance and regulations, and are designed to ensure that complaints are dealt with in an appropriate and timely manner. However, if there are examples where this is not the case then I would welcome the opportunity to review them. The view of the complainant is always respected and should the complainant request a complaint be managed formally this will always be dealt with under PTR regardless of the content of the complaint.

I welcome your feedback and am happy to work with you to ensure that we deliver our responsibilities under PTR effectively and in line with the regulations at all times.

Yours sincerely

Gill Harris
Executive Director of Nursing and Midwifery

During the last five years our family have had to endure the mistreatment and subsequent avoidable death of our loved one, The CHC have worked for my family and other Tawel Fan families quietly and diligently.

In the days before the CHC became involved we had to try and navigate a very complex and technical complaints system completely alone, we often felt that we had no voice and no one to listen or to turn too.

The CHC have become indispensable to my family, not just in navigating the complex systems and processes of the NHS but much more than that.

The Chief Officer and support staff have stood shoulder to shoulder with my family at very difficult meetings, stood up for our rights when others would try to disregard them or worse still try to take them away from us. They have been a confidante, an unofficial support system or a clear head in the face of overwhelming emotions or muddled thoughts but most of all they have given our family and others a voice when we often would have had none.

Our journey would have been far more difficult without the CHC maybe even impossible, we would have possibly given up as it can be a lonely place dealing with complex and emotional matters alone and as a family we will always be grateful for the help they have given us.

John & Ann Stewart

Agenda Item 7

Document is Restricted

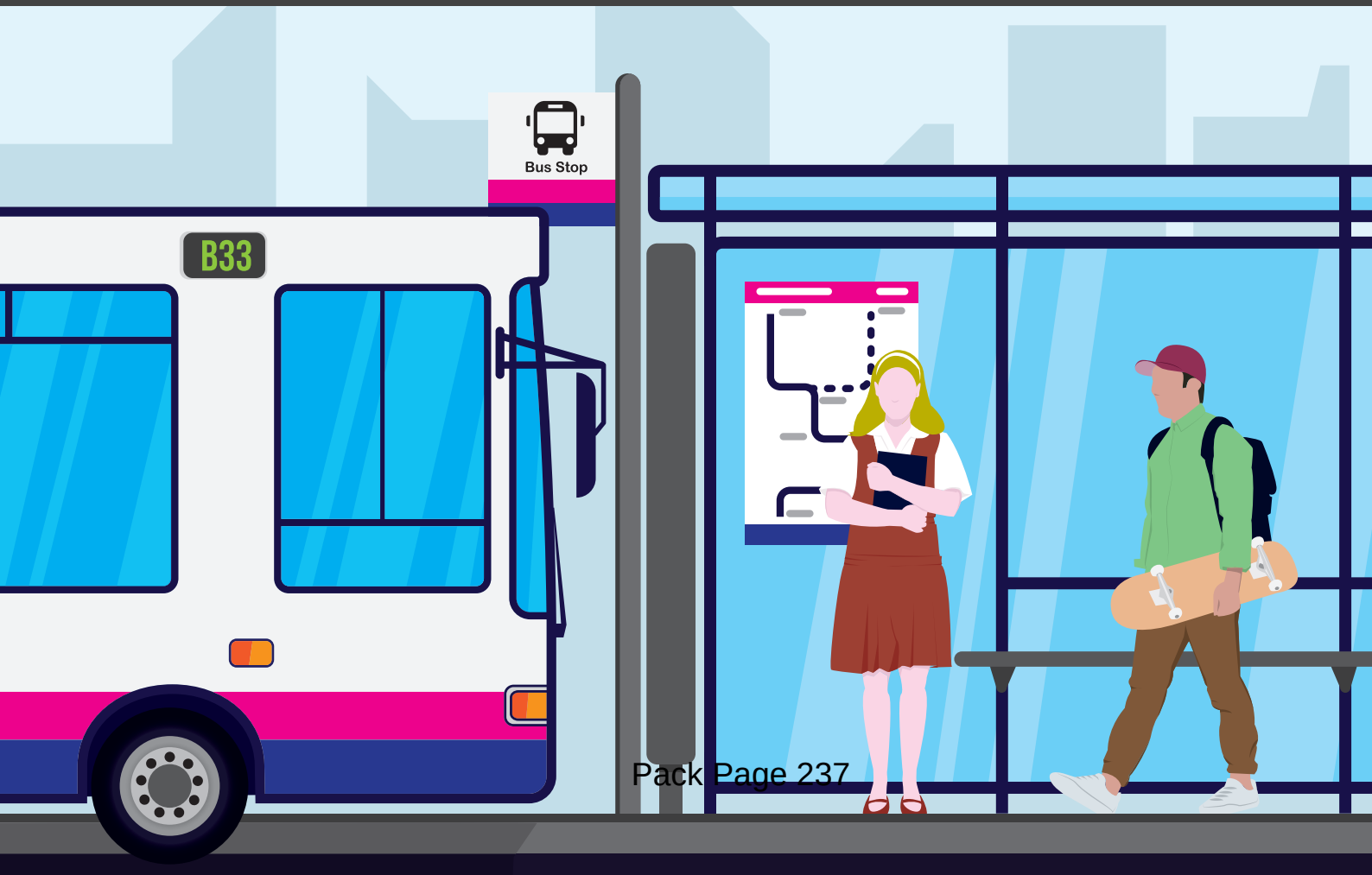
Document is Restricted

January 2019

Archwilydd Cyffredinol Cymru
Auditor General for Wales

The Welsh Government's youth discounted bus fare scheme – 'MyTravelPass'

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



This report has been prepared for presentation to the National Assembly under the Government of Wales Act 2006.

The Wales Audit Office study team comprised Seth Newman and Stephen Lisle under the direction of Matthew Mortlock.

Wales Audit Office
24 Cathedral Road
Cardiff
CF11 9LJ

Contents

Summary report

What this report is about

The MyTravelPass scheme

1 **MyTravelPass** is the Welsh Government's youth discounted bus fare scheme. The scheme, which is managed on the Welsh Government's behalf by PTI Cymru Ltd[1] under the MyTravelPass brand, aims to improve young people's access to education, employment, training and leisure opportunities. Through the scheme, 16 to 18 year olds[2] have been able to receive a discount of a third off the price of any bus journey that they make wholly or partly within Wales[3]. Operators are eligible for the Welsh Government's Bus Services Support Grant[4] providing they offer this discount through the scheme[5]. The MyTravelPass scheme applies to local bus services and the longer distance 'TrawsCymru' network. It does not cover coach services, such as National Express and Megabus.

2 In September 2014, Welsh Government Ministers had announced plans for a pilot discounted bus fares scheme for young people aged 16 and 17 for the purposes of training and employment. The announcement of the scheme was part of a political agreement with the Welsh Liberal Democrats in advance of the draft 2015-16 budget. The Welsh Government confirmed a £14.75 million budget for the pilot period. MyTravelPass initially ran as a pilot between September 2015 and March 2017 but with an enhanced offer covering 16 to 18 year olds regardless of the journey purpose.

1 PTI Cymru Ltd is a not-for-profit company, primarily funded by the Welsh Government. Its core function is the provision of impartial, comprehensive public transport information. Its remit was extended to administer the youth discounted bus travel scheme in advance of the scheme's launch. Consequently, a separate division was established which operates under the 'MyTravelPass' brand.

2 Eligibility expired on a young person's 19th birthday.

3 We have described MyTravelPass as a 'discounted' scheme throughout this report to reflect the basis of the scheme and distinguish it from the concessionary (free travel) scheme for older and disabled persons. However, some Welsh Government documentation that we have reviewed has referred to it as a concessionary fares scheme.

4 The Bus Services Support Grant is allocated annually to Wales' local authorities and is used to subsidise socially necessary bus and community transport within their areas. The grant supplements local authorities' own expenditure on bus and community transport services.

5 Some operators have maintained their own discounted ticket arrangements despite the introduction of the scheme.

3 In February 2017, the Cabinet Secretary for Economy and Transport announced that the scheme would continue while a new enhanced scheme was determined. Between October 2017 and January 2018, the Welsh Government ran a consultation[6] on the scheme's future and possible changes. Those possible changes included reviewing the age of eligibility and the level of discount, monthly or annual fees, as well as extending the scheme to other groups, such as carers and volunteers. The consultation document noted that encouraging young people to use bus transport could deliver wider social, economic and environmental benefits.

4 The Welsh Government published a summary[7] of responses to the consultation in June 2018. In October 2018, the Welsh Government's draft budget for 2019-20 included provision for an increased £2 million budget to enhance the scheme. In November 2018, the Cabinet Secretary for Economy and Transport confirmed that the scheme would be extended to cover 16 to 21 year olds with effect from early December 2018. However, technical issues have delayed the official launch.

Our audit work

5 In October 2017, the [then] Auditor General for Wales received correspondence from an Assembly Member raising concerns about the scheme. Specifically, the correspondence questioned the scheme's value for money during 2015-16 and 2016-17. Those concerns stemmed from published information about the scheme's costs, relative to take-up of the passes and the costs of other commercially available discounted bus travel options.

6 In May 2018, following preliminary enquiries with the Welsh Government, the Auditor General wrote to the National Assembly's Public Accounts Committee explaining plans to report on this topic. The Auditor General indicated that the issues raised through that audit work merited further consideration by the Committee.

7 This report is deliberately limited in its scope. It sets out the key facts about budget announcements made and decisions that the Welsh Government took in setting up the MyTravelPass scheme and then continuing it beyond its initial pilot phase. It also considers the costs of the scheme and its uptake by young people.

6 Welsh Government, **Discounted Bus Travel for Younger Persons in Wales**, October 2017.

7 Welsh Government, **Consultation – summary of response, Discounted bus travel for younger people in Wales**, June 2018

8 We have not examined the wider administration of the scheme or the overall outcomes it has delivered, recognising that the future of the scheme was already under review by the Welsh Government itself. We have limited our evidence gathering to the Welsh Government. We have not sought the views of bus operators, local authorities, service-users or any other interested parties on the design or operation of the scheme. We make no comment about the future of the scheme and its merits, which is a policy matter for the Welsh Government.

9 Appendix 1 sets out our audit approach. Appendix 2 describes early costings by the Welsh Liberal Democrats and later Welsh Government estimates that underpinned the scheme's budget in 2015-16 and 2016-17. Appendices 3 and 4 set out the scheme's actual costs and data on uptake and estimated journeys. Appendix 5 provides a timeline of key events and decisions.

Key findings

10 The **MyTravelPass** scheme has cost significantly less to operate since the start of 2017-18 compared with the initial 19-month pilot period between September 2015 and March 2017, even accounting for any up-front implementation costs (Figure 1). The lower costs since the start of 2017-18 reflect the fact that the compensation being paid to operators is now taking account of actual use. The scale of the difference raises obvious questions about the value for money of the £14.74 million of expenditure during the initial period.

11 Welsh Government officials have suggested that this expenditure needs to be seen in the context of additional benefits secured from the funding provided in the period to March 2017 amid wider concerns about the financial resilience of the bus industry. The overall take-up of the scheme has been significantly lower than suggested by early Welsh Government estimates.

12 The £14.75 million budget for the pilot period was announced as part of a political agreement in September 2014. Welsh Government officials were unable to provide any documentary evidence to show how the budget figures set out in autumn 2014 were arrived at, as they were not involved in the decision-making about those figures.

13 Welsh Government officials have explained to us that negotiations with the bus industry about the scheme were made difficult by the fact that the budget for the scheme had already been declared publicly. In that context, officials have emphasised that these negotiations were successful in securing an enhanced scope for the scheme when compared with the original announcement in September 2014, and all-Wales coverage.

14 In advice to Ministers in March 2015 – seeking formal approval to take forward the scheme – officials explained that although the scheme gave funding to private bus companies, the level of compensation would comply with 'state aid' rules. The expectation set out in the advice was that arrangements for compensating bus operators would be supported by the introduction of a smartcard system to record actual journeys, although this later proved not to be possible. Initial costings set out in that advice assumed that 80% of 16 to 18 year olds (90,000 young people) would take up passes and use them on average twice a week, making 9 million journeys per year.

15 Because smartcard systems were not enabled, the Welsh Government compensated operators based solely on a formula allocation, rather than taking account of actual take-up and journeys, but officials did not seek Ministerial approval for this change. Officials have suggested that the formula approach agreed with bus operators mitigated any state aid risk to some extent by ensuring no operator in Wales (existing or potential new entrant) obtained a competitive commercial advantage during the pilot phase.

16 While the overall budget for the pilot period remained unchanged, uptake of the scheme was much lower than estimated, with less than 10% of eligible young people applying for passes by the end of March 2017 (9,867 applications in total to that point)[8]. In February 2017, officials told Ministers formally that expenditure had not been based on actual discounted journeys but said that the funding had also helped stabilise the bus network, supporting services that would have been withdrawn otherwise.

17 The Welsh Government determined that the scheme would continue in 2017-18 but with a budget of £1 million and compensation for operators taking account of actual use. Since April 2017, the Welsh Government has been able to monitor ticket sales data through on-board electronic-ticketing machines. During 2017-18, the Welsh Government spent £1.09 million on the scheme with 1,343,659 discounted journeys estimated. By the end of 2017-18, there had been a total of 19,503 applications since the commencement of the scheme. These figures remained significantly less than the Welsh Government's original estimates.

8 Some of these applications were not completed so the number of actual passholders by this point would have been lower (Figure 1). In addition, some passholders would have seen their cards expire by this point on their 19th birthday.

18 The scheme continued into 2018-19 on the same basis as in 2017-18. In April 2018, the Cabinet Secretary agreed the £1 million total budget for 2018-19 to meet the cost of compensation of operators in 2018-19 and for the marketing and promotion of the new scheme. The cumulative number of applications had increased to 26,181 by the end of September 2018, with 14,939 live passes in circulation as at 13 August 2018.

19 The data currently available for 2018-19 shows 362,221 estimated journeys for the first quarter of the financial year (to 30 June 2018 inclusive). This compares with 458,083 estimated journeys in the equivalent period in 2017-18, although the figure for 2018-19 may still be subject to amendment to reflect delayed claims.

Figure 1: key facts about the Welsh Government's 'MyTravelPass' scheme

Financial year	Total cost of scheme (£ million)	Number of journeys estimated[1]	Number of applications for passes[2]	Cumulative applications for passes[2]
2015-16[3]	5.00	Not recorded	5,647	5,647
2016-17	9.74	Not recorded	4,220	9,867
2017-18	1.09	1,343,659	9,636	19,503
2018-19	1.00[4]	362,221[5]	6,678[6]	26,181[6]

Notes:

1. The number of journeys is an estimate based on the number of discounted tickets sold of different types (including four journeys for day tickets, 10 journeys for weekly tickets and 40 journeys for monthly tickets). In practice, some journeys made with weekly or monthly tickets may occur in a later period to the one that they are counted against.
2. The number of applications includes young people who passed through the age and residency checks but where the application process was not completed. This may have been because a suitable photo was not supplied and attempts to contact the applicant to obtain a suitable photo were not successful. We understand that this may have been a particular issue during the first period in 2015-16. As at 13 August 2018, there were 14,939 live passes in circulation, from a total of 20,953 passholders since the commencement of the scheme and 21,940 recorded applications. We do not have the equivalent data to compare at earlier points in time.
3. The scheme ran from September 2015 to March 2016 and not for the full financial year although young people could apply for passes in August 2015.
4. Budgeted costs for 2018-19 (prior to the announcement that the scheme will be extended to cover 16 to 21 year olds).
5. Up to and including 30th June 2018, although this figure may be subject to amendment to reflect delayed claims.
6. Up to and including 30th September 2018.

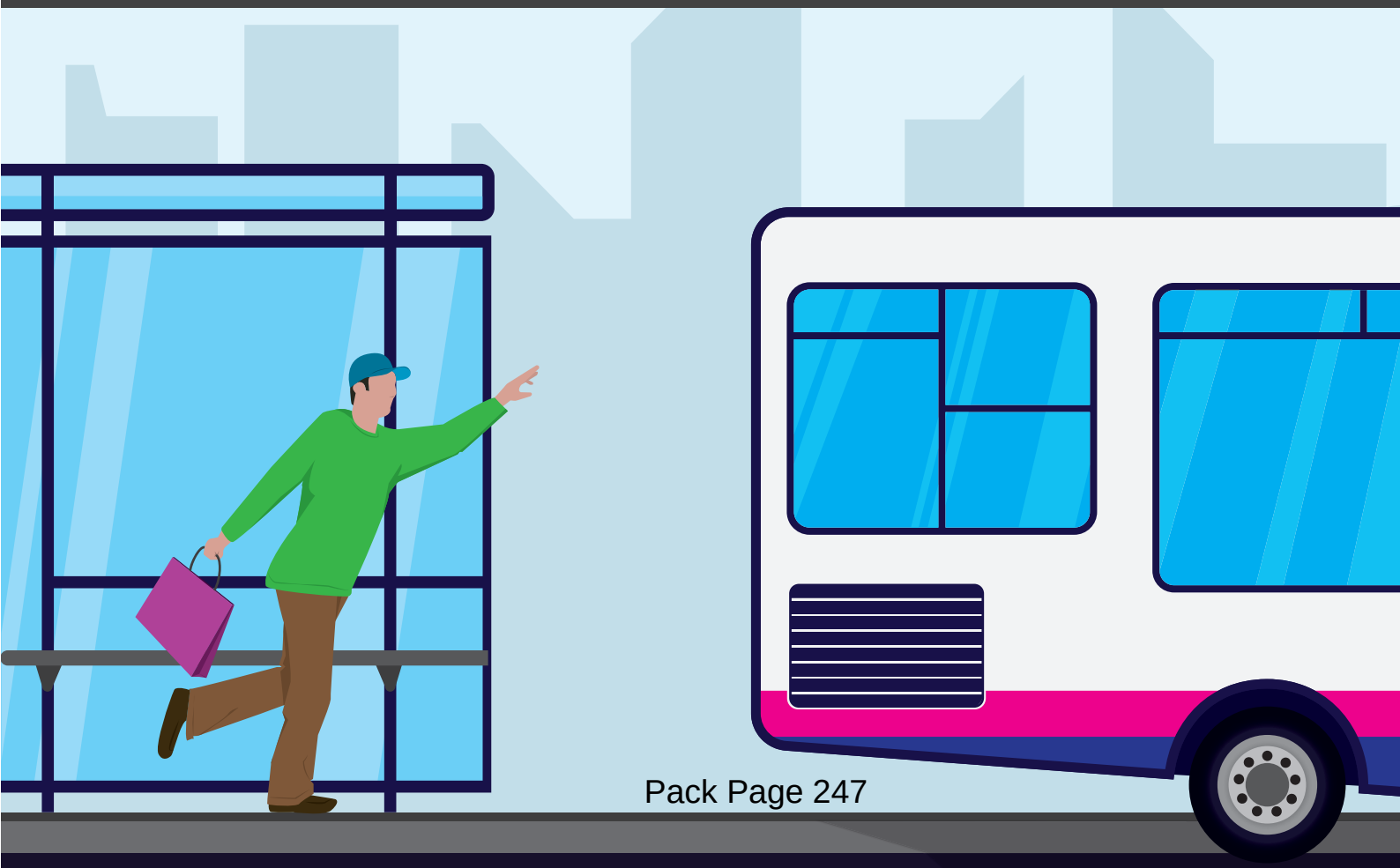
Source: Welsh Government

20 In response to issues that we raised during our review, the Welsh Government's internal audit service initiated a review of controls around the scheme expenditure, focused on arrangements for the 2017-18 financial year. The internal audit service reported its findings in November 2018. The report provided only a 'limited assurance' rating in respect of the controls in place. The internal audit service will follow up in due course on the actions that are being taken to respond to the findings in its report.

21 As part of the response to the internal audit review, Welsh Government officials have discussed with Wales Audit Office staff opportunities for further audit certification to validate that funds received by local authorities have been passed on to the bus operators. Such work would complement existing certification arrangements for the concessionary fares scheme for older and disabled people and the Bus Services Support Grant.

Part 1

The introduction of MyTravelPass in September 2015



Welsh Ministers initially announced plans for a discounted bus fare scheme for 16 and 17 year olds to cover travel to and from work or training and with a budget of £5 million for 2015-16 and £9.75 million for 2016-17

1.1 In March 2014, the Welsh Liberal Democrats published a policy report[9] that recommended introducing a discounted bus fare scheme for young people aged 16 to 18, or possibly even up to 24 years of age. The policy report suggested that such a scheme would improve access for young people to education, employment and training opportunities. It estimated that the scheme would cost between £2.4 million and £40.6 million per year depending on the level of discount and age-range eligibility (Figure A1, Appendix 2). The Welsh Liberal Democrats' cost estimates were based on the costs of the existing concessionary fare scheme for older and disabled people in Wales.

1.2 In June 2014, a report by the Bus Policy Advisory Group[10] made recommendations on the availability of good quality, commercially sustainable transport services in Wales. The group had been asked by the Minister for Economy, Science and Transport to review the costs and benefits of different types of concessionary travel schemes for young people. The group supported the principle of such a scheme. However, it recommended that the policy be developed through further research and consultation, before a specific course was decided upon. To our knowledge, those actions were not taken forward at the time. Welsh Government officials have noted that the political funding decision took precedence over the normal policy formulation process.

1.3 In an oral statement on the Welsh Government's draft budget for 2015-16, delivered in September 2014, the Minister for Finance and Government Business outlined plans for a discounted bus fare scheme for 16 and 17 year olds for travel to and from work or training. At this stage, the Welsh Government did not confirm the level of discount that it was proposing for individual journeys. However, the draft budget provided for £5 million of expenditure on the scheme in 2015-16[11].

9 Welsh Liberal Democrats, **A Concessionary Fare Scheme for Young People in Wales**, March 2014.

10 Bus Policy Advisory Group, **Report of the Bus Policy Advisory Group**, June 2014. The report notes that the group 'brought together bus operators, local authorities, a health board representative and bus users. Welsh Government officials provided a secretariat function.

11 Welsh Government, **Draft Budget 2015-16, Priorities for Wales**, September 2014.

1.4 The Welsh Government's commitment to the scheme was part of a wider two-year political agreement with the Welsh Liberal Democrats[12]. Welsh Government officials have emphasised to us that the announcement came at a time when the Welsh Government's core Bus Services Support Grant allocation had been held at £25 million annually since 2013-14, reflecting wider pressures on the Welsh Government's budget. The scheme therefore provided an unexpected opportunity to boost the bus industry at a time of limited resources, promoting use by young people and contributing potentially to a longer-term modal shift from cars to buses. The Bus Policy Advisory Group's June 2014 report had noted that bus services in Wales were facing considerable challenges, including reductions in financial support for services from public bodies and a decline in the number of fare paying passengers.

1.5 As part of the National Assembly's scrutiny of the Welsh Government's draft budget proposals for 2015-16, the Welsh Government submitted a memorandum[13] to the Enterprise and Business Committee on 16 October 2014. The memorandum confirmed a £5 million budget for the youth discounted fare scheme in 2015-16 and a £9.75 million budget for 2016-17. This funding announcement was made prior to agreeing with bus operators the scope of the scheme and how they would be compensated.

1.6 We have not explored the political negotiations that led to the budget agreement between the Welsh Government and the Welsh Liberal Democrats. However, we asked Welsh Government officials for any underpinning analysis of the estimated costs of the scheme. Welsh Government officials were unable to provide any documentary evidence to show how the figures set out in the draft budget were arrived at, as they were not involved in the decision-making about those figures.

1.7 In December 2014, the Welsh Government's final budget for 2015-16[14] confirmed a new £5 million budget line to support the youth discounted fare scheme but did not provide any further detail for 2016-17.

12 Other measures covered by the agreement related to the Pupil Deprivation Grant, apprenticeships, support for childcare costs, and transport projects.

13 Welsh Government, **Memorandum on the Economy, Science and Transport (EST) Draft Budget Proposals for 2015/16**, October 2014.

14 Welsh Government, **Final Budget 2015-16**, December 2014.

Later, Ministers approved an enhanced discount scheme for 16 to 18 year olds regardless of the journey purpose, but based on the same budget assumptions for 2015-16 and 2016-17

1.8 In March 2015, Welsh Government officials submitted initial advice to the Minister for Economy, Science and Transport on discounted bus travel for young people. The advice sought approval for a scheme that differed from that proposed in the budget announcement of September 2014 (paragraph 1.3). In that announcement, the intention was for a scheme limited to 16 and 17 year olds travelling to and from work or training. The new scheme described in March 2015 enhanced the total offering. It covered all 16, 17 and 18 year olds and all journeys across Wales regardless of the journey purpose[15]. The scheme would offer a one-third discount on fares, to commence in September 2015.

1.9 Welsh Government officials have explained to us that negotiations with the bus industry about the scheme in advance of this advice to the Minister were made difficult by the fact that the budget for the scheme had already been declared publicly. Specifically, that the industry had made clear that it expected those undertakings about funding levels to be met in full if its members were to participate and fulfil the Welsh Ministers' public commitments. In that context, officials have emphasised to us that these negotiations were successful in securing an enhanced scope for the scheme when compared with the original announcement in September 2014 and all-Wales coverage[16]. The advice to the Minister did not articulate the difficulties of negotiating with operators when they were aware of the amount of funding that was available to the scheme.

1.10 In addition to the flat-lined budget for the Bus Services Support Grant (paragraph 1.4), Welsh Government officials have noted that concerns about a potential budget shortfall against previous commitments for the older and disabled persons scheme in 2016-17 influenced the negotiations. In the event, the Welsh Government was able to meet that commitment[17].

15 The proposals set out in the Ministerial advice had followed discussions between Welsh Government officials, local authority officers and the Confederation of Passenger Transport (CPT). The CPT is the trade association representing the bus and coach industry.

16 Officials have explained that a key consideration in extending the scope of the scheme to cover all journeys was that discussions with the industry concluded that fewer restrictions would speed up boarding and make it easier to record journeys. Also, that it would be difficult in practice to prove the purpose of a journey.

17 The Welsh Government is under a statutory obligation to compensate operators under the older and disabled persons scheme with the objective that they are no worse off.

1.11 The advice to the Minister in March 2015 explained that the funding for the scheme would be allocated through the Bus Services Support Grant, a mechanism familiar to both local authorities and bus operators[18]. The Welsh Government had made clear to operators that any payments under the grant would be contingent on their participation in the young persons discount scheme, although it had no powers to compel operators to participate[19]. All bus companies providing local bus services in Wales are eligible to seek compensation from the Welsh Government for carrying 16 to 18 year olds at a one-third discount.

1.12 The advice recognised that there were already discounts available to some young people through certain bus operators[20]. However, it noted that because these discounts were not universal, this created complexity for young people. The advice also suggested that the scheme had the potential to offer an alternative to discretionary post-16 years home-to-school transport services that were increasingly being withdrawn by local authorities.

1.13 Welsh Government officials have explained to us that the standard discount for child fares was one-third of the equivalent adult fare. Therefore, although consideration was given to offering a higher discount for eligible young persons, this would have led to a situation where a person in full-time employment could receive a higher discount than school pupils under the age of 16. There was a concern that operators would have been under pressure to reduce all commercial fares for persons under 16, with severe financial consequences.

1.14 Consistent with indications in the 2015-16 budget (paragraph 1.7), the advice recommended that £5 million should be committed to the scheme in 2015-16 and with an estimated £9.75 million requirement in 2016-17. The advice made clear that the £5 million sum for 2015-16 included costs for implementing the scheme, ongoing marketing/management as well as compensation for the cost of discounted travel between September 2015 and March 2016. The Minister for Economy, Science and Transport approved the introduction of discounted bus travel for young people aged 16 to 18 on the basis set out in the advice.

18 The advice noted that new legislation would have been required to empower the Welsh Ministers to administer concessionary travel directly rather than through local authorities.

19 The advice had noted that there was the option of developing new legislation to make the provision of discounted travel for young people a mandatory requirement but noted that this would take some time.

20 The advice stated that many large bus operators were providing discounted travel for 16 to 18 year olds. It did not quantify more specifically the coverage of discounted fares or describe the level of discounts provided (or the range).

Officials told Ministers that although the scheme gave funding to private bus companies, the level of compensation would comply with 'state aid' rules

1.15 The advice from Welsh Government officials to the Minister in March 2015 highlighted state aid risks under European Union rules. Specifically, it emphasised the need to demonstrate compliance with regulation 1370/2007/EC on public passenger transport services by rail and by road[21].

1.16 Under this regulation, public funding to bus operators could constitute unlawful state aid by creating a competitive advantage for the recipients. However, the regulation allows for funding to be provided as a Public Service Obligation (PSO). PSOs can be established to compensate an operator for a deficit incurred in providing a service that would not otherwise be commercially viable.

1.17 The advice included an assurance that the calculation of compensation payments was underpinned by sound financial analysis to support compliance with the PSO rules. The Welsh Government has not provided us with any further financial analysis other than that set out within the Ministerial advice itself (paragraphs 1.20 to 1.25).

1.18 The advice explained that compensation payments to bus operators would be assessed against actual take-up and use of the scheme, as well as the costs of marketing and card production. It was intended that funding allocations to bus operators would be provided in proportion to the number of discounted journeys recorded and adjusted to take account of rural/urban characteristics. The advice noted that this approach would ensure that no more of the budget than necessary would be spent and that operators would be no better and no worse off.

1.19 The expectation set out in the advice was that arrangements for compensating bus operators would be supported by the introduction of a smartcard system, although this later proved not to be possible (paragraphs 2.2 to 2.3).

21 Regulation (EC) No 1370/2007 of the European Parliament and of the Council of Europe 23 October 2007 on public passenger transport services by rail and by road and repealing Council Regulations (EEC) Nos 1191/69 and 1107/70.

Initial costings assumed that 80% of 16 to 18 year olds would take up passes and use them on average twice a week

1.20 The March 2015 Ministerial advice provided an indication of how the £5 million budget for 2015-16 might be allocated (Figure 2). The advice made clear that these were estimated figures, with the assumptions based on certain but limited evidence, for example, about take-up and use.

Figure 2: costs estimated by the Welsh Government for the MyTravelPass scheme in 2015-16

£3.96 million in compensation to bus operators for discounted journeys in the period September 2015 to March 2016 – with the advice explaining that other costs would need to be constrained within the remainder of the budget.

£1.0 million in other costs including

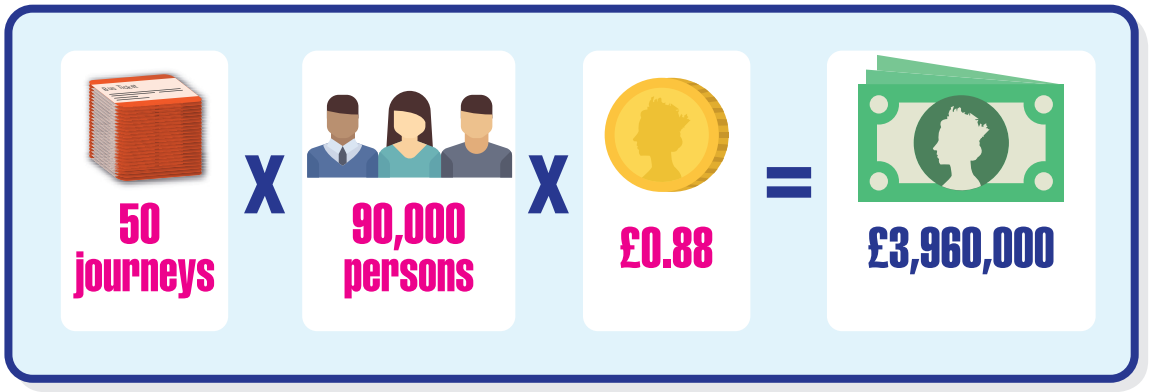
- **£240,000 for the purchase of 20 new electronic-ticketing machines[1].**
- **£60,000 for the reconfiguration of software as some existing electronic-ticketing machines would not have been able to accommodate a new category of concession.**
- **£50,000 for marketing and promotion.**
- **£400,000 for the production of 100,000 passes[2].**
- **£250,000 for the assessment of applications, provision of a helpline and monthly monitoring to be undertaken by Traveline Cymru.**

Notes:

1. Welsh Government officials have explained to us that these estimates included both the purchase of machines and other changes to back-office equipment, such as additional system categories to differentiate youth discount cards from mandatory concessionary fare cards.
2. Welsh Government officials have explained to us that the estimated costs per pass were based on local authorities' reported costs for passes they provide for older or disabled concessionary bus pass holders. Although the estimated cost accounted for 100,000 passes, the estimated sum for compensation for discounted journeys assumed 90,000 pass holders in 2015-16.

Source: Welsh Government estimates, March 2015

1.21 Figure A2 in Appendix 2 provides more detail about the assumptions[22] underpinning the estimated £3.96 million compensation allocation for discounted journeys in the period September 2015 to March 2016. The calculation was based on the anticipated number of journeys per passholder and the average compensation contribution to meet the fares shortfall:



1.22 The Welsh Government's initial calculation assumed that 90,000 young people would engage in the scheme during 2015-16. This represented 80% of the 113,000 people aged 16 to 18 in Wales. The basis for that assumption was not explained, although the advice also stated that 83% of young people used a bus three or more times a week[23].

1.23 The advice assumed that passholders would make 100 journeys on average over a full year but assumed 50 journeys on average for the seven-month period from September 2015 to March 2016. The advice referenced the number of journeys each year under the concessionary fares scheme for older and disabled people[24]. It suggested that although not free, younger passholders would be more active and likely to use their passes more often. The Welsh Government's compensatory amount of £0.88 for each journey was based on a third of the average fare reimbursed under the concessionary scheme for older and disabled people.

22 The Welsh Government calculated its estimates on a different basis to the approach applied by the Welsh Liberal Democrats in their March 2014 policy paper and applied different assumptions. These differences mean that the two sets of estimates cannot be compared directly.

23 Welsh Government officials have indicated that this figure on bus use would have included home-to-school travel but have been unable to clarify the source.

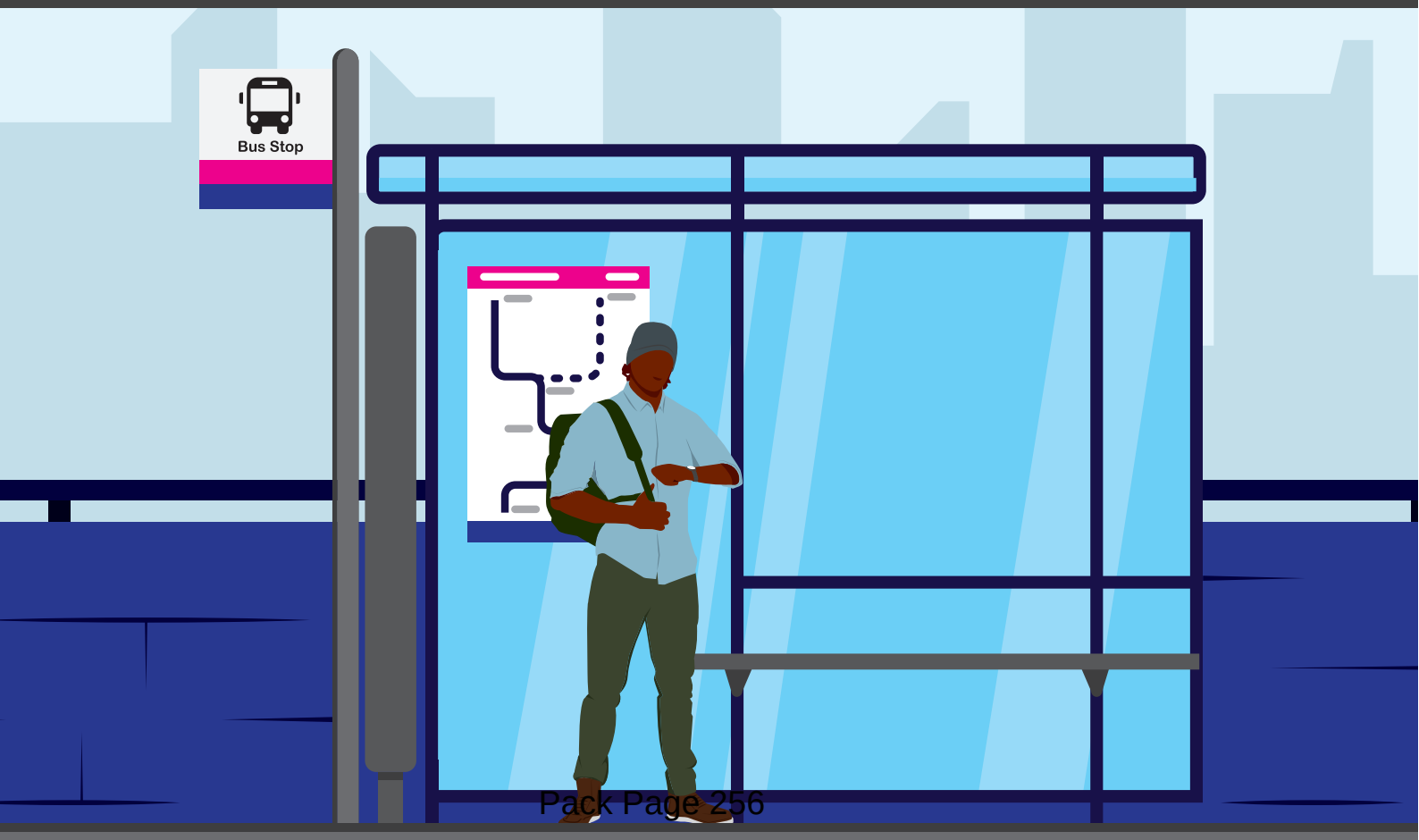
24 The advice cited an expectation of around 40 million journeys in 2015-16 across around 730,000 passholders, which would have been equivalent to around 55 journeys per passholder.

1.24 The estimates in the Ministerial advice provided an indication of the maximum level of demand that could be accommodated within the budget allocation. The advice did not provide details of any sensitivity analysis to assess the impact of different levels of uptake, journeys or average discounts on the scheme budget. As noted in paragraph 1.17, the Welsh Government has not provided us with any further financial analysis other than that set out within the Ministerial advice itself.

1.25 The advice acknowledged the previously estimated budget provision of £9.75 million for 2016-17. It stated that, while 2016-17 would not require the full start-up costs incurred in 2015-16, there was likely to be a continued need for some marketing and that the number of journeys was likely to increase proportionately because of favourable experiences during 2015-16. The advice did not provide any further explanation of the basis of the 2016-17 budget figure but noted that the actual sums allocated would be based on data collected during 2015-16 and actual achievements in 2016-17.

Part 2

The operation of MyTravelPass between September 2015 and March 2017



The Welsh Government compensated operators based solely on a formula allocation, rather than taking account of actual take-up and journeys, but officials did not seek Ministerial approval for this change

2.1 As noted in paragraphs 1.15 to 1.18, Ministerial advice in March 2015 had provided assurances about the management of state aid risks. In particular, the advice emphasised that the compensation to operators would be assessed against actual take-up and use of the scheme, and the costs of marketing and card production, to ensure operators were not over-compensated.

2.2 At that time, Wales Audit Office staff had been in contact with Welsh Government officials after the Chair of the National Assembly's Public Accounts Committee raised concerns with the Auditor General about the concessionary fare scheme for older and disabled people. As part of those enquiries, Welsh Government officials had advised us in summer 2015 that the proposed young persons' scheme would not use smartcard passes from the outset, as had been hoped (paragraph 1.19). Rather, the passes would be enabled so they could be activated as smartcards[25] at a future time when rigorous testing of the ticketing machines' compatibility had been completed.

2.3 Although activation of the smartcard facility was expected, Welsh Government officials have explained that it was later concluded that the associated transaction costs would be too expensive and disruptive, with a risk of abortive costs reflecting the 'pilot' status of the scheme. Smartcards are used for the concessionary fares scheme for older and disabled persons. However, the compensation arrangement for that scheme is based on an average adult single fare. The intention was that the MyTravelPass scheme would apply to all journeys and the bus industry had agreed to provide the one-third discount to all journeys regardless of ticket type. While benefiting all users, Welsh Government officials have explained that this approach increased the complexity of recording, as there was considerable variation in the purchase price. With a finite number of fares that can be stored on electronic-ticketing machines, it became evident that a technical solution could not be delivered in the timescale without diluting the offer to users.

25 Each eligible person would be provided with a pass on application to join the scheme. Pass holders would show the pass to drivers when boarding buses to show they were eligible for the discounted fare and, once smartcard enabled, the pass would allow the discounted fare to be recorded on the buses' electronic-ticketing machines.

2.4 We were informed as part of our previous enquiries in 2015 that Welsh Government funding would be allocated not based on actual journeys, but instead on a formula agreed between the Welsh Government, the bus industry and local authorities, that took account of registered mileage and journeys recorded under the existing concessionary scheme for older and disabled people and the profile of the 16 to 18 year old population. However, the formula applied did not include any consideration of the profile of the 16 to 18 year old population. Welsh Government officials have explained that it was decided that the number of eligible young people in an area might not reflect actual trip patterns and could have resulted in a less equitable solution.

2.5 These arrangements for the allocation and distribution of the funding differed from the expectations set out in the Ministerial advice from March 2015[26]. During this latest review, we therefore asked Welsh Government officials whether there had been any formal approval for this change in arrangements.

2.6 Despite potential state aid risks, there was no further Ministerial advice at that stage. The March 2015 advice had indicated that further advice would be submitted on the arrangements for the smartcard passes, but this was not done. Welsh Government officials have recognised that, in hindsight, the revised compensation mechanism should have been reported to the Minister once negotiations with the bus industry about the arrangements had been completed. They have also suggested that the formula approach that was agreed mitigated any state aid risk to some extent by ensuring no operator in Wales (existing or potential new entrant) obtained a competitive commercial advantage during the pilot phase.

2.7 In December 2015, the Welsh Government's draft budget for 2016-17 showed an allocation of £9.75 million for the scheme in line with the political agreement with the Liberal Democrats. The final budget in March 2016 confirmed the allocation. In March 2016, Welsh Government officials asked the Minister for Economy, Science and Transport to approve the continuation of the scheme in 2016-17. The advice to the Minister reiterated that this was a pilot scheme, with funding committed to the end of 2016-17. The advice stated that there were no issues of regularity or propriety. The advice made no mention of the way in which the funding was being allocated, other than confirming that the payments would be made via grant to local authorities. It did not provide any information about take-up of the scheme to that point.

26 We had not seen the March 2015 Ministerial advice at the time of those previous enquiries.

While the overall budget remained unchanged, uptake of the scheme was much lower than estimated, with less than 10% of eligible young people applying for passes by the end of March 2017

2.8 Journeys supported by the scheme commenced in September 2015[27]. Figure A4 in Appendix 3 shows how the 2015-16 and 2016-17 funding was distributed on a regional basis. The Welsh Government started making payments in the second quarter of the financial year (July to September 2015). Draft guidance for bus operators had been created for the pilot period. However, there is no record of it having been issued. There has also been an absence of any formal documentation between the Welsh Government and related parties to ensure that accountability, roles, responsibilities and duration of duties were clear, right through to the end of 2017-18. This issue has now been rectified for 2018-19 by issuing grant award letters. Fresh guidance is being prepared for 2019-20.

2.9 The Welsh Government had initially estimated compensation costs of £3.96 million for discounted journeys in 2015-16 and £0.3 million for other costs that would fall to operators in respect of electronic ticketing machines (Figure 2). However, it paid out a total of £4.74 million of the available budget to operators under the revised compensation arrangements, with the majority of that funding provided in the second and third quarters of the financial year (Figure 3). At £0.26 million, other central management costs were substantially lower than the £0.7 million estimated in March 2015. One key difference being the much lower number of passes needing to be issued than estimated (paragraph 2.13). To secure their participation in the scheme, the Welsh Government had agreed to allocate all the remaining budget to operators under the agreed formula rather than reducing the budget in light of the lower management costs, with the same arrangement applying in 2016-17.

2.10 Welsh Government officials have confirmed that the compensation payments were front-loaded to account for the likely profile of any one-off implementation costs but also to reflect concerns about operators' cashflow. In addition to purchasing any new electronic ticketing machines, it was expected that existing machines would have to be reconfigured to accept what was a new product. Operators did not have to evidence actual expenditure in respect of these costs. Rather, the Welsh Government was expecting these costs to be absorbed as part of the compensation determined by the agreed formula. In 2016-17, the Welsh Government distributed the funding on a more even basis through the year. In practice, the investment required to put the infrastructure in place to provide discounted fares data was not completed until the end of 2016-17.

27 Young people were able to apply for passes in the previous month and there was public information about the scheme in July 2015.

Figure 3: quarterly breakdown of the Welsh Government's compensation of operators in 2015-16 and 2016-17

	2015-16[1]			2016-17			
	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar
£ (millions)	2.0	2.0	0.74	2.44	2.44	2.44	2.16
% of total for financial year	42	42	16	26	26	26	23

Note:

1. The scheme ran from September 2015 to March 2016 and not for the full financial year, although young people could apply for passes for a six-day period at the end of August 2015 to enable those persons to travel at a discount as soon as the scheme began.

Source: Welsh Government

2.11 We do not have a full breakdown of the funds provided to individual operators. Bus operators received 96% of the budget for the scheme during the period. Spending on other areas such as publicity and marketing only accounted for a very small proportion of the overall budget. Overall, the scheme cost £14.74 million in the period to March 2017, with a small amount of the 2016-17 budget unspent (Figure A3, Appendix 3).

2.12 On 14 January 2016, the Minister for Economy, Science and Transport gave evidence to the Enterprise and Business Committee as part of the National Assembly's scrutiny of the Welsh Government's draft 2016-17 budget. During that evidence session, the Committee heard that only around 4,000 young people had applied for passes at that time, although there was no acknowledgement that this figure would have included some applications that were not completed.

2.13 By the end of March 2016, 5,647 young people had applied for a MyTravelPass (Figure A7, Appendix 4). This represented 6% of the estimated 90,000 uptake estimated in the Welsh Government's March 2015 costings (paragraph 1.22 and Figure A2, Appendix 2). By the end of 2016-17, with the scheme operational for 19 months, there had been 9,867 applications, or 11% of the previous estimate. The overall number of applications represented just 9% of the young people potentially eligible based on the 113,000 estimate in the March 2015 advice.

2.14 Some of the passes issued will have expired as passholders reached 19 years of age. In addition, the number of applications includes young people who passed through the age and residency checks but where the application process was not completed. This may have been because a suitable photo was not supplied and attempts to contact the applicant to obtain a suitable photo were not successful. We understand that this may have been a particular issue during the first period in 2015-16. We have not obtained a figure for the number of actual passholders in the period to or as at March 2017. However, comparisons based on more recent cumulative data suggest that the figure would have been at least 5% lower than the number of applications (paragraph 3.20).

2.15 Electronic-ticket machines were not used to record the number of discounted journeys across the whole of Wales until April 2017. We have seen no evidence that the Welsh Government carried out any analysis of the actual usage of passes during the pilot period through other means. This is despite assurances in the initial March 2015 Ministerial advice that this would be undertaken to ensure no more of the budget was spent on the scheme than was necessary.

2.16 There is no data available centrally to confirm the extent to which young people taking up passes were already frequent bus users and/or were already able to benefit in their locality from discounted fares that may have been offered previously by commercial operators. Welsh Government officials have noted that operators were reluctant to withdraw commercial discount schemes because they remained unconvinced that MyTravelPass would continue. This may have affected take-up. Welsh Government officials have also noted that the application rate has been seen to be higher in some areas where dominant operators have removed their own products.

In February 2017, officials told Ministers formally that expenditure had not been based on actual discounted journeys, but said that the funding had also helped stabilise the bus network

2.17 In February 2017, Welsh Government officials submitted advice to the Cabinet Secretary for Economy and Infrastructure about the continuation of the scheme into 2017-18. The advice reprised the history of the scheme. It referred to the fact that it had not been possible to negotiate an agreement governing the pilot phase with the bus operators and local authorities based on the actual number of recorded journeys, and which would have ensured the scheme was introduced by the (September 2015) deadline announced by the Minister for Finance and Government Business in September 2014.

2.18 The advice pointed to the state aid risk and the need to ensure that bus operators were not overcompensated. It described the alternative payment arrangements that had been put in place for the period to March 2017 but did not set out explicitly how this risk was managed in the context of those alternative arrangements. As noted in paragraph 2.6, the alternative payment arrangements that the Welsh Government subsequently put in place for the period to March 2017 were not subject to Ministerial approval.

2.19 The advice acknowledged that although highlighted as a new discounted bus travel scheme for younger people, it had achieved additional indirect benefits. These indirect benefits included assisting in stabilising and supporting the bus network, which was said to have been experiencing relatively modest profitability. Welsh Government officials have emphasised to us that, in their view, the expenditure on the scheme during the period to March 2017 needs to be seen in the context of the other benefits referred to in the advice. They also highlighted again the wider funding pressures that provided the context to negotiations with the bus industry about the scheme (paragraph 1.4) and their belief that state aid risks were mitigated to some extent through the reimbursement formula, with new entrants to the market also eligible.

2.20 The advice suggested that the funding had allowed services to be supported that would have been withdrawn otherwise. The advice went on to emphasise the extent of the bus network's overall vulnerability by highlighting the termination of three small to medium sized bus operators. The advice did, however, recognise that some of the responsibility for this was caused by poor management decisions. Welsh Government officials have emphasised to us that the failure of bus operators for reasons of poor management or fraud reduces the bus network and competition for local authority contracted services. Few operators are keen to step in to fill gaps left by what are perceived to be unviable bus service networks, especially during a time of very limited public funding[28].

2.21 The Ministerial advice from March 2015 that confirmed the funding for the period to 31 March 2017 made little reference to these wider benefits; nor did the March 2016 advice about the funding for 2016-17. However, the March 2015 advice did acknowledge that the scheme could generate more journeys by fare-paying passengers, thereby generating additional revenue for the industry. The level of uptake to date suggests that any such benefits are likely to have been marginal at best so far, and it is not known how many of those taking up the pass may already have been frequent bus users.

28 The advice noted that it was in response to the demise of these operators that the Minister/ Cabinet Secretary had announced in September 2016 a 'Five Point Plan' for the bus industry in Wales.

Part 3

The operation of MyTravelPass since April 2017

The Welsh Government determined that the scheme would continue in 2017-18 but with a budget of £1 million and compensation for operators taking account of actual use

3.1 Towards the end of the pilot period, organisations including the National Union of Students, called for the Welsh Government to retain the scheme. The Welsh Government's draft budget for 2017-18 published in October 2016 had shown a reduction of £9.75 million to zero for the scheme. Welsh Government officials have explained that negotiations with the bus industry for continuing the scheme started in autumn 2016. There was still no clear commitment to continuing the scheme by the time of the final Welsh Government 2017-18 budget in December 2016.

3.2 In February 2017, Welsh Government officials submitted advice to the Cabinet Secretary for Economy and Infrastructure (paragraph 2.17). The advice set out various discount and eligibility options for a future legacy scheme[29]. The discount options included a one-third discount, a 50% discount and a 100% discount/free travel. The age-range options included 16 to 18 years, 16 to 22 years and 16 to 24 years.

3.3 The advice invited the Cabinet Secretary to agree the continuation of the scheme from 1 April 2017 and retain the one-third discount for 16 to 18 year olds. However, the advice indicated that the scheme could be supported with a significantly reduced budget of up to £1 million in 2017-18. As part of that total cost, the advice indicated that the estimated requirement to compensate bus operators for the number of journeys carrying discounted young people could range from £589,000 and £805,000 during 2017-18. There was a discrepancy between the formal advice and the underpinning spreadsheet tables provided with the advice which highlighted a range from just under £539,000 to £805,000.

29 The advice indicated that the Cabinet Secretary had already expressed a wish to see an affordable legacy scheme operate.

3.4 The costings underpinning the advice adopted a baseline assumption of an average fare of £2.25, lower than the £2.64 figure used for the assumptions in the March 2015 advice. Welsh Government officials have suggested to us that this lower figure reflected the actual pattern of take-up of ticket options by MyTravelPass holders based on data available at the time from some operators. The figure used in the March 2015 advice was based on the older and disabled persons' free concessionary bus travel scheme, which reflects the cost of a single fare (paragraph 1.23)[30]. Similarly, the assumptions about the number of passholders were lower, accounting for take-up to that point, as was the assumption about the number of journeys per pass (paragraph 2.13 and Figure A7, Appendix 4).

3.5 The costings assumed that passes would be used by 10% of eligible young people (11,100 passes) making a total of 888,000 journeys in a year (80 per passholder)[31]. The range in costs presented in the advice modelled the combined effect of a 10% increase or decrease from the base assumptions for the average fare and in the number of journeys per pass. Again, Welsh Government officials have suggested to us that the estimate of 80 journeys per passholder in a year – lower than the 100 journeys assumed in March 2015 – was based on the data available from some operators at the time. However, they have been unable to provide supporting evidence. In addition, assurances given about the basis for the financial analysis were not relevant as they related to reviews of the concessionary fares scheme for older and disabled people.

3.6 The February 2017 advice also outlined that, from 1 April 2017, local authorities would compensate bus operators based on the actual number of journeys recorded via electronic ticketing machines on buses. Compensation would be based on a formula taking account of the number of recorded journeys multiplied by a 'representative fare' and 'reimbursement rate'.

30 Negotiations with operators meant that the one-third discount applies to all tickets, including, for example, day, weekly or monthly tickets which already have an element of discount built in when compared with single fares.

31 Even for the option of free travel for 16 to 18 year olds, the underpinning analysis estimated costs from a baseline assumption of 49,950 passholders making 5.49 million discounted journeys a year. These estimates for free travel were considerably lower than the March 2015 estimates for a one-third discount (paragraph 1.22).

3.7 The representative fare was the fare that 16 to 18 year olds would have been required to pay in the absence of the scheme – the equivalent adult fare for the ticket purchased. The reimbursement rate made allowance for extra costs incurred by bus operators such as fuel, extra vehicles or higher insurance. It also made allowance for the number of additional journeys generated by the existence of the scheme, which would otherwise have not been undertaken. The advice explained that the mechanism would broadly mirror that used to compensate bus operators under the concessionary fares scheme for older and disabled people.

3.8 On 21 February 2017, the Cabinet Secretary for Economy and Transport announced his intention to launch a new youth travel pass in 2018 following a consultation exercise. He confirmed that he had reached agreement with local authorities and the bus industry that the existing discounted bus travel arrangements would continue to be available to 16 to 18 year olds throughout Wales from 1 April 2017.

3.9 The advice to the Cabinet Secretary about the compensation mechanism for 2017-18 had noted that it was being refined. In the end, the Welsh Government agreed to compensate operators based on the actual discounts applied to individual tickets rather than applying a formula based on the representative fare and reimbursement rate. The Cabinet Secretary was not informed of this change in any later advice.

3.10 The Cabinet Secretary also noted that he had asked the Confederation of Passenger Transport to come forward with proposals for a new marketing campaign to increase the take-up and use of passes [32]. Evidence presented by the Welsh Government to the National Assembly's Economy, Infrastructure and Skills Committee in July 2017[33] indicated that £120,000 (including VAT) had been set aside as part of the scheme budget to meet the cost of that campaign.

32 The advice from officials in February 2017 cited some findings from market research work commissioned on the Welsh Government's behalf in late 2015-16. However, it noted that no further active marketing had been undertaken to that point because of the uncertainty about the funding of the scheme beyond 31 March 2017.

33 Welsh Government, **Memorandum on the Economy and Infrastructure, 2017/18 In-Year Financial Scrutiny Session**, Economy, Infrastructure and Skills Committee – 13 July 2017.

3.11 Welsh Government officials have explained that marketing activity in the early period of the MyTravelPass scheme focused on social media, according to Welsh Government marketing recommendations. The second phase was developed by the Confederation of Passenger Transport and undertaken on its behalf by MyTravelPass. It focused more on face-to-face contacts. The campaign has continued, but at a lower level, pending Ministers' decisions about what a new scheme should include. The Confederation has submitted a report to the Welsh Government on its marketing campaign that is being evaluated by officials alongside options for a new scheme. There was a notable increase in MyTravelPass applications in the second half of 2017 (Figures A7 and A8, Appendix 4).

3.12 There has been no formal agreed marketing contract and plan against which performance could be evaluated, and with departure requests needing to be made retrospectively to address the fact that the marketing work has not been put out to open tender.

During 2017-18, the Welsh Government spent £1.09 million on the scheme with 1,343,659 discounted journeys estimated

3.13 Since April 2017, the Welsh Government has been able to monitor ticket sales data through on-board electronic-ticketing machines. Drawing on that information, figures provided by the Welsh Government estimate that the total number of journeys made during 2017-18 was 1,343,659 (Figure A5, Appendix 4). This figure was significantly less than the Welsh Government's original estimate of 9 million journeys per year, based on 90,000 passholders (Figure A2, Appendix 2).

3.14 There was substantial variation in the number of journeys estimated from month to month, and in the type of tickets sold that supported those figures (Figure A6, Appendix 4). The overall number of journeys estimated ranged from 54,331 in November 2017 to 166,404 in May 2017. Day tickets accounted for the largest single proportion of the total estimated journeys across the year (42%).

3.15 The evidence presented by the Welsh Government to the National Assembly's Economy, Infrastructure and Skills Committee in July 2017 (paragraph 3.10) indicated that 9,250 passes had been issued since the commencement of the scheme and against an age cohort of 110,000. There had been a total of 10,908 applications by the end of June 2017 (Figure A7, Appendix 4). Some of these applications will not have been completed (paragraph 2.14). However, we have been unable to confirm with the Welsh Government the exact basis of the passes-issued figure reported to the Committee. By the end of 2017-18, there had been a total of 19,503 applications.

3.16 The Welsh Government has confirmed that 109% of the £1 million budget for 2017-18 was spent. That expenditure included £792,308 in compensation to bus operators (Figure A3, Appendix 3). The Welsh Government's internal audit review has highlighted some discrepancies from a sample of claims reviewed – with examples of both under and over payments. The review also highlighted weaknesses in the documentation of claims monitoring.

The scheme continued into 2018-19 on the same basis as in 2017-18 until the Welsh Government decided recently to extend the eligible age range

3.17 In June 2018, the Welsh Government published a summary of responses to its October 2017 to January 2018 consultation about the future of MyTravelPass. The summary reported that there was strong agreement among respondents that lower bus fares influence young people's choice of transport. A large proportion of respondents felt that current discount levels were not enough and there was strong support for increasing the age range and number of people eligible for the scheme such as those in recognised apprentice schemes or undertaking voluntary work.

3.18 While it highlighted potential funding pressures, the summary made clear that the Cabinet Secretary for Economy and Transport had indicated his hope that the age range of the scheme would be increased to those aged 21 years during 2018. In July 2018, the Welsh Government began negotiations with the bus industry for a new voluntary Youth Travel scheme, with an extended age range up to 21 years old based on actual use. In October 2018, the Welsh Government's draft budget for 2019-20 included provision for an increased £2 million budget to enhance the scheme. In November 2018, the Cabinet Secretary for Economy and Transport confirmed the extended age range and indicated that this would take effect from early December 2018. However, technical issues have delayed the official launch.

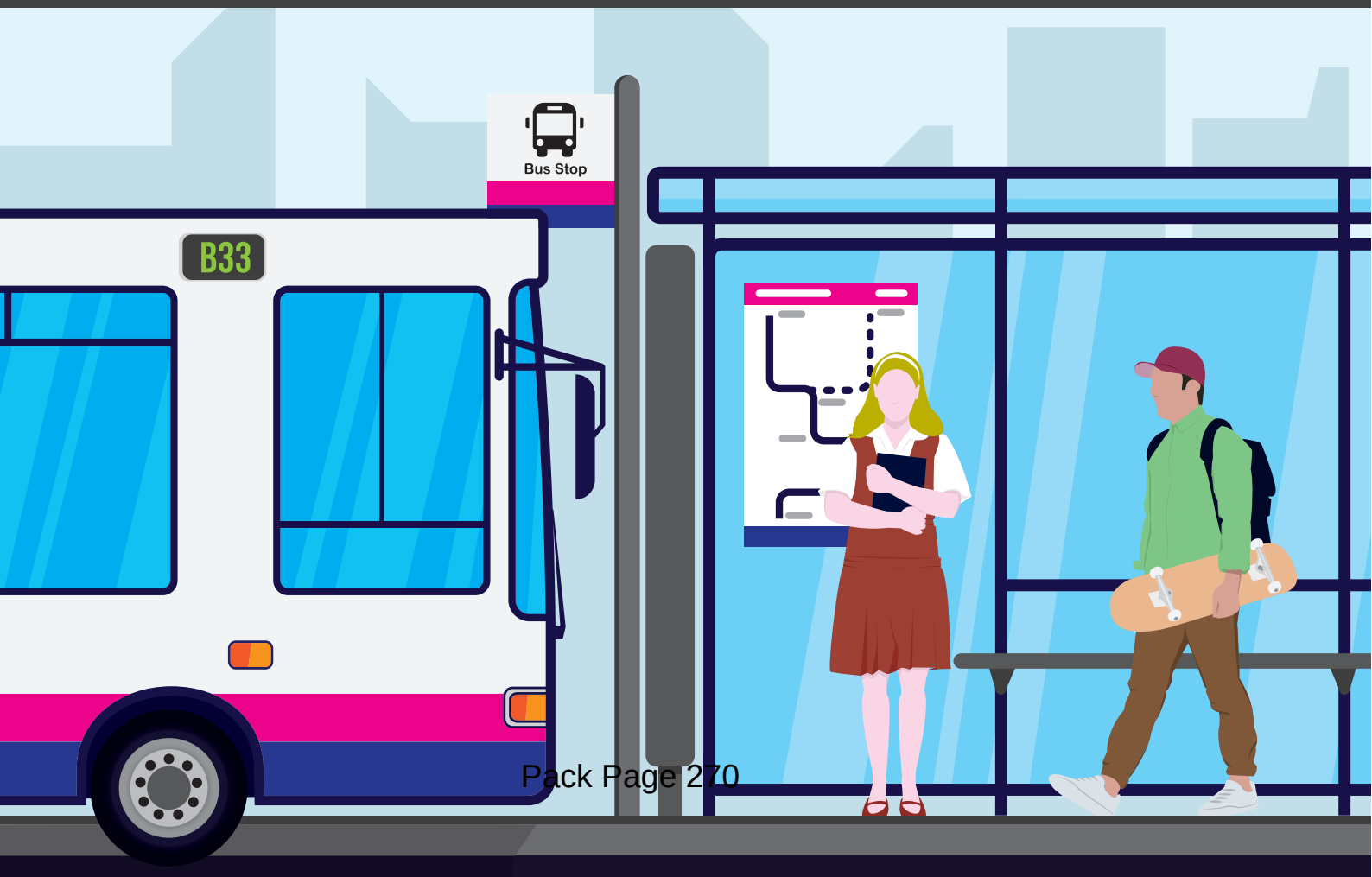
3.19 In the meantime, the scheme continued on the same basis as in 2017-18. In April 2018, the Cabinet Secretary agreed the £1 million total budget for 2018-19 to meet the cost of compensation of operators in 2018-19 and for the marketing and promotion of the new scheme. The advice to the Cabinet Secretary explained that the 2018-19 budget included an indicative £150,000 for ongoing marketing and administration for the existing scheme and any replacement (which could be targeting a wider group for a possibly different offer).

3.20 As at 13 August 2018, there were 14,939 live passes in circulation, from a total of 20,953 passholders since the commencement of the scheme and 21,940 applications[34]. The total number of applications since the commencement of the scheme had increased to 26,181 by 30 September 2018 (Figure A7, Appendix 4).

3.21 The data currently available for 2018-19 shows 362,221 estimated journeys for the first quarter of the financial year (to 30 June 2018 inclusive). This compares with 458,083 estimated journeys in the equivalent period in 2017-18 (Figure A5, Appendix 4), although the figure for 2018-19 may still be subject to amendment to reflect delayed claims.

34 We do not have the equivalent data to compare at earlier points in time.

Appendices



Appendix 1 – Our audit approach and methods

Scope

The scope of this report is limited and focuses on the decisions that the Welsh Government took in setting up and continuing to fund the MyTravelPass scheme. It also considers the costs and uptake between September 2015 and March 2018.

We focused on the underpinning analysis and advice that supported the Welsh Government's decision-making about the funding of the scheme in the period to March 2017, although our report comments on arrangements for 2017-18 and 2018-19. The Welsh Government's internal audit service has completed a review that examined the controls around expenditure on the scheme in 2017-18 (paragraphs 20 to 21).

We have not examined the wider administration of the scheme nor the overall outcomes it has delivered. We make no comment about the future of the scheme and its merits, which is a policy matter for the Welsh Government.

Methods

In undertaking the review, we:

- met with Welsh Government officials currently responsible for the administration of the scheme and the Welsh Government's internal auditors;
- reviewed documentary evidence provided from the Welsh Government, including formal Ministerial advice and information on the take-up of the scheme[35];
- made further enquiries of current Welsh Government officials based on our review of that information; and
- prior to publication, we agreed the factual accuracy of our report with the Welsh Government.

Because of the limited scope of our review, we have not sought the views of bus operators, local authorities, service-users or any other interested parties on the way the scheme has operated, nor their engagement in decisions about the design of the scheme.

35 Full trend data to show the number of passholders over time is not readily available. We focused on the data that the Welsh Government had been tracking on the number of recorded applications and, since the start of 2017-18, estimated journeys based on ticket sales.

Appendix 2 – Early estimates of the costs for discounted bus travel for young people

The Welsh Liberal Democrats' cost estimates – March 2014

The introduction of MyTravelPass was part of a budget agreement between the Welsh Government and the Welsh Liberal Democrats in September 2014. This agreement came ahead of the publication of the Welsh Government's draft 2015-16 budget (paragraph 1.3). In March 2014, the Welsh Liberal Democrats published a policy paper that explored various policy options and estimated costs for the provision of additional subsidy so that bus operators could offer discounted travel.

The report did not seek to estimate any upfront implementation costs. However, it suggested that administration costs would be low as it could operate without the need for dedicated eligibility cards. The report suggested that discounts could be offered on the basis of official proof of age cards already in operation such as PASS (Proof of Age Standards Scheme) cards, driving licences and student ID cards, in addition to visual verification where possible.

Figure A1: Welsh Liberal Democrats' cost estimates for different policy options – March 2014[1]

	1/3 discount	50% discount	100% discount
16 to 18 year olds[2]	£2.4 million- £2.8 million	£3.7 million- £4.2 million	£7.3 million- £8.4 million
16 to 24 year olds[3]	£11.7 million- £13.4 million	£17.7 million- £20.3 million	£35.4 million- £40.6 million

Notes:

1. These costings were based on estimates of the per person costs for the all-Wales concessionary bus fare scheme for older and disabled people over the previous three years. Although the exact basis of the calculation is not clear from the report, it estimated a range in costs of between £95 and £109 per person.
2. Although the report was calling for a scheme covering 16 to 18 year olds and presented the costings in this way, the cost estimates for 16 to 18 year olds applied the range of per person costs to the 77,100 people aged 16 and 17 in Wales.
3. The cost estimates for 16 to 24 year olds were based on there being 372,515 people aged 16 to 24 in Wales. The report recognised that not all of this number would be in full-time education, but that the costings would provide an approximate calculation of the maximum extent of funding required to include students and young people studying an apprenticeship.

Source: Welsh Liberal Democrats, **A Concessionary Fare Scheme for Young People in Wales**, March 2014.

Welsh Government cost estimates – March 2015

Advice submitted by Welsh Government officials to the Minister for Economy, Science and Transport in March 2015 set out the assumptions underpinning the estimated costs that the Minister was asked to approve. The Welsh Government calculated its estimates on a different basis to the approach applied by the Welsh Liberal Democrats in their March 2014 policy paper and applied different assumptions. These differences mean that the two sets of estimates cannot be compared directly.

Figure A2 sets out some of the key assumptions underpinning the 2015-16 estimate for the cost of compensation for discounted journeys (£3.96 million). Figure 2 in the main report shows how the other estimated costs of £1 million in 2015-16 were broken down. Paragraphs 1.5 and 2.7 comment on the estimated £9.75 million cost of the scheme for 2016-17.

Figure A2: some key assumptions underpinning the Welsh Government's 2015-16 estimate of £3.96 million for the compensation of discounted journeys

Item	Figures	Explanation
Average cost per journey	£2.64	Based on expectations of some 40 million journeys under the mandatory scheme for persons resident in Wales aged 60 and over or who are disabled at an average fare of £2.64.
Average discount per journey	£0.88	One-third of the average cost per journey for young persons' travel.
Persons resident in Wales aged 16 to 18 years	113,000	
Number of young people taking up passes	90,000	80% of the 113,000 persons resident in Wales aged 16 to 18 years.
Frequency of bus use by young people	83% travelling three or more times a week	The advice noted that 83% of young people use a bus three or more times a week (data source not referenced).

Item	Figures	Explanation
Average number of journeys per person and per year under the scheme	100	Compared with figures showing that people travelling under the mandatory scheme for those aged 60 and over who are disabled were taking on average 55 journeys per year. Advice noted that although the young persons' scheme would not be free, younger passholders would be likely to be more active. The advice did not specify how the figure of 100 was arrived at.
Average number of journeys per person in the period September 2015 to March 2016	50	Half of the annual figure estimated above, but for seven of 12 months of the year.

Source: Wales Audit Office review of Welsh Government Ministerial Advice, **Discounted Bus Travel for Young People**, March 2015.

Appendix 3 – Costs reported by the Welsh Government for the MyTravelPass scheme – September 2015 to March 2018

Figure A3: annual cost breakdown for scheme (September 2015 to March 2018)

	Total budget	Compensation to bus operators	Management costs	Unspent	Overall proportion of expenditure allocated to bus operators
2015-16	£5 million	£4.74 million	£0.26 million	£0.001 million	95%
2016-17	£9.75 million	£9.47 million	£0.27 million	£0.007 million	97%
2017-18	£1 million	£0.79 million	£0.30 million	Not applicable	79%

Note:

Management costs include marketing and administration of pass applications and technical support. The main body of our report explains why these costs were greater in 2015-16 and 2016-17 than in 2017-18.

Source: Welsh Government

Figure A4: regional distribution of funding for compensation of bus operators, 2015-16, 2016-17 and 2017-18

	2015-16				
	Quarter 1[1]	Quarter 2	Quarter 3	Quarter 4	Year
South East Wales[2]		£970,760	£970,760	£359,181	£2,300,701
South West Wales[3]		£400,980	£400,980	£148,362	£950,322
North Wales[4]		£505,360	£505,360	£186,983	£1,197,703
Mid Wales[5]		£122,900	£122,900	£45,473	£291,273
Wales		**£2,000,000**	**£2,000,000**	**£740,000**	**£4,740,000**

	2016-17				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
South East Wales[2]	£1,175,265	£1,175,265	£1,175,265	£966,290	£4,492,085
South West Wales[3]	£507,804	£507,804	£507,804	£455,056	£1,978,469
North Wales[4]	£604,013	£604,013	£604,013	£587,582	£2,399,620
Mid Wales[5]	£150,418	£150,418	£150,418	£153,144	£604,398
Wales	**£2,437,500**	**£2,437,500**	**£2,437,500**	**£2,162,072**	**£9,474,572**

	2017-18				
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year
South East Wales[2]	£15,625	£17,675	£25,274	£24,565	£83,138
South West Wales[3]	£19,524	£27,453	£22,674	£38,592	£108,243
North Wales[4]	£180,970	£78,293	£178,281	£157,268	£594,812
Mid Wales[5]	£1,254	£266	£973	£3,621	£6,114
Wales	**£217,373**	**£123,686**	**£227,202**	**£224,047**	**£792,308**

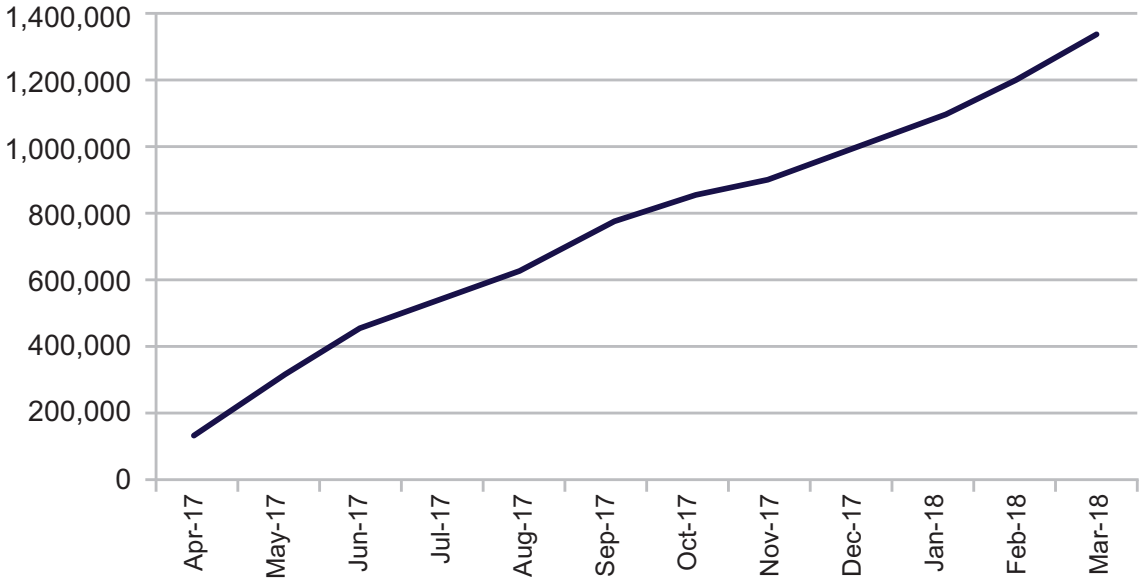
Notes:

1. Scheme commenced in Quarter 2 2015-16.
2. Blaenau Gwent, Bridgend, Caerphilly, Cardiff, Merthyr Tydfil, Monmouthshire, Newport, Rhondda Cynon Taf, Torfaen and the Vale of Glamorgan.
3. Carmarthenshire, Neath Port Talbot, Pembrokeshire and Swansea.
4. Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd Wrexham.
5. Ceredigion and Powys.

Source: Welsh Government

Appendix 4 – Data on the number of pass applications and estimated journeys

Figure A5: the cumulative number of journeys estimated through the MyTravelPass scheme during 2017-18

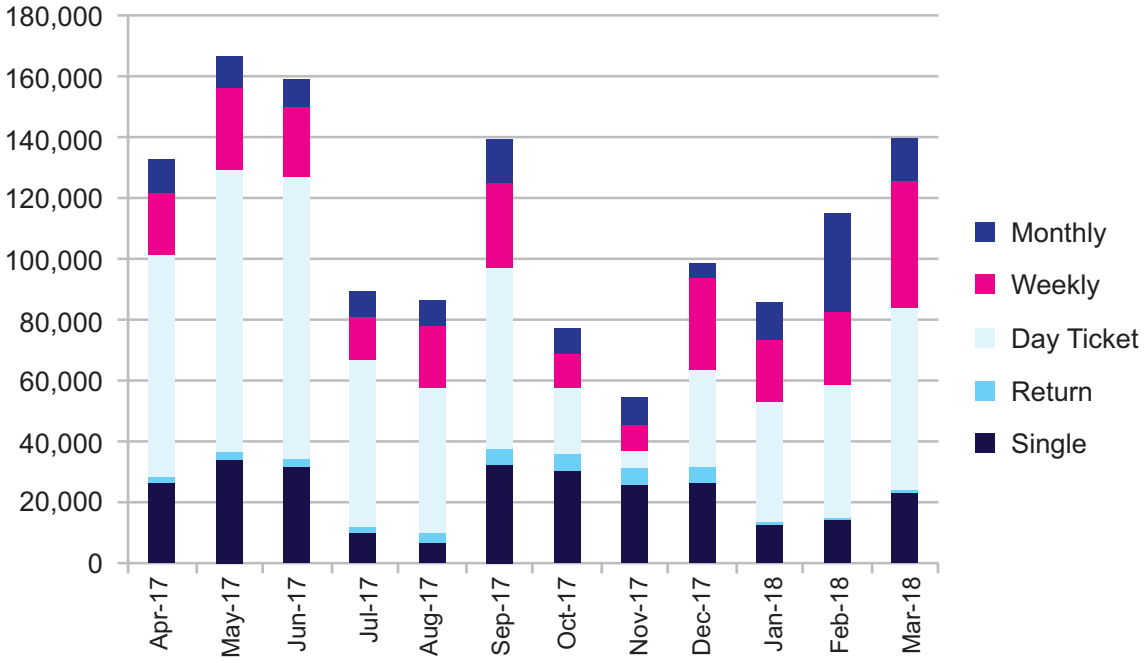


Note:

The number of journeys is an estimate based on the number of discounted tickets sold of different types (including four journeys for day tickets, 10 journeys for weekly tickets and 40 journeys for monthly tickets). In practice, some journeys made with weekly or monthly tickets may occur in a later period to the one that they are counted against.

Source: Welsh Government

Figure A6: number of journeys by ticket type estimated through the MyTravelPass scheme during 2017-18

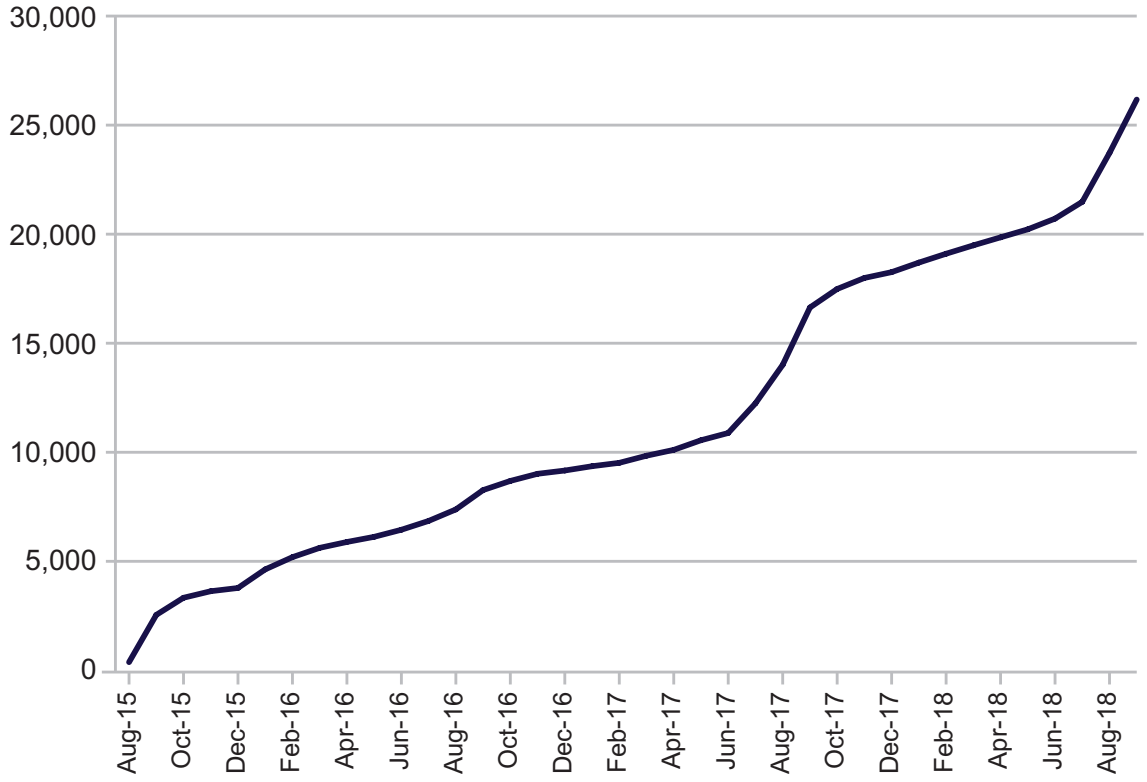


Note:

The number of journeys is an estimate based on the number of discounted tickets sold of different types (including four journeys for day tickets, 10 journeys for weekly tickets and 40 journeys for monthly tickets). In practice, some journeys made with weekly or monthly tickets may occur in a later period to the one that they are counted against.

Source: Welsh Government

Figure A7: the cumulative number of MyTravelPass applications recorded since the introduction of the scheme, August 2015 to September 2018

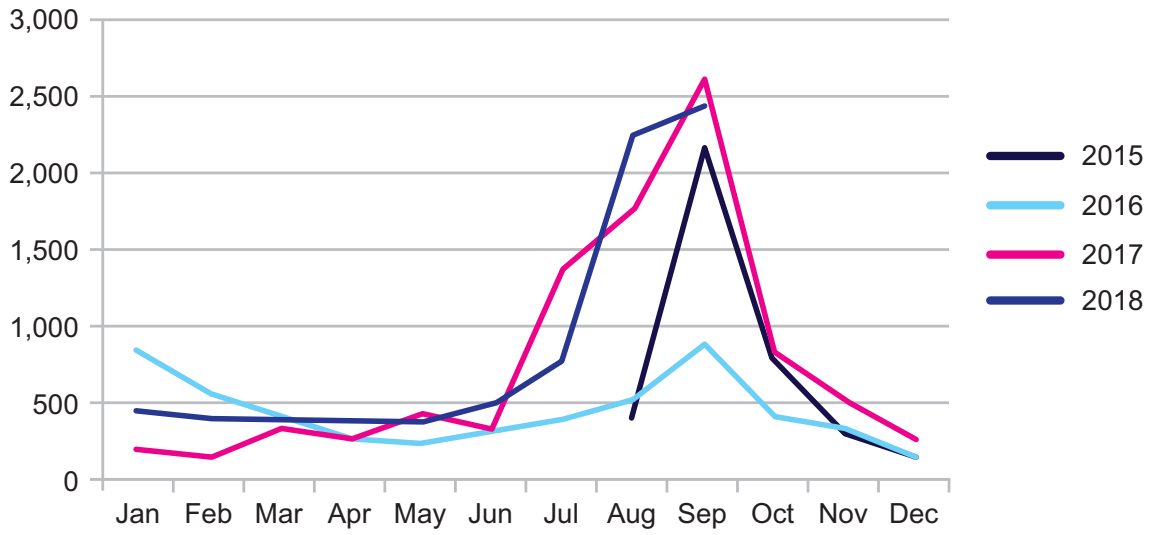


Notes:

1. This is the cumulative number of passes that have been applied for overall rather than the number of valid passes issued or in circulation at a particular time. The passes expired on the passholder's 19th birthday. In addition, the number of applications includes young people who passed through the age and residency checks but where the application process was not completed. This may have been because a suitable photo was not supplied and attempts to contact the applicant to obtain a suitable photo were not successful. We understand that this may have been a particular issue during the first period in 2015-16. As at 13 August 2018, there were 14,939 live passes in circulation, from a total of 20,953 passholders since the commencement of the scheme and 21,940 applications. We do not have the equivalent data to compare at earlier points in time.
2. August 2015 covered a six-day period only.

Source: Welsh Government

Figure A8: the number of MyTravelPass applications by month on common axes, August 2015 to September 2018



Note:
August 2015 covered a six-day period only.
Source: Welsh Government

Appendix 5 – Timeline of key events/decisions

2014

MAR – Welsh Liberal Democrats publish a policy report **'A Concessionary Fare Scheme for Young People in Wales'**

JUN – Report of the bus policy advisory group recommends establishment of a working group to further consider the feasibility of a youth concessionary fare scheme

SEP – Public Ministerial announcement of plans for the scheme, with the draft Welsh Government budget confirming a £5 million allocation for 2015-16

OCT – Explanatory papers provided by the Welsh Government to support scrutiny of the draft 2015-16 budget confirm £5 million for the scheme for 2015-16 and £9.75 million in 2016-17

2015

MAR – Ministerial advice from Welsh Government officials seeking agreement to commence the scheme following approval of the final 2015-16 budget. Advice indicates that compensation to operators will take account of actual take-up and using smartcard passes

JUN – Negotiation agreed with bus industry for compensation on a formula basis and not on actual take up

JUL – Information about the scheme is published

AUG – Pass application process starts

SEP – MyTravelPass scheme is officially launched, running initially until March 2017

DEC – Draft Welsh Government budget for 2016-17 contains details of intention to continue the young people discounted bus fare scheme with a budget of £9.75 million

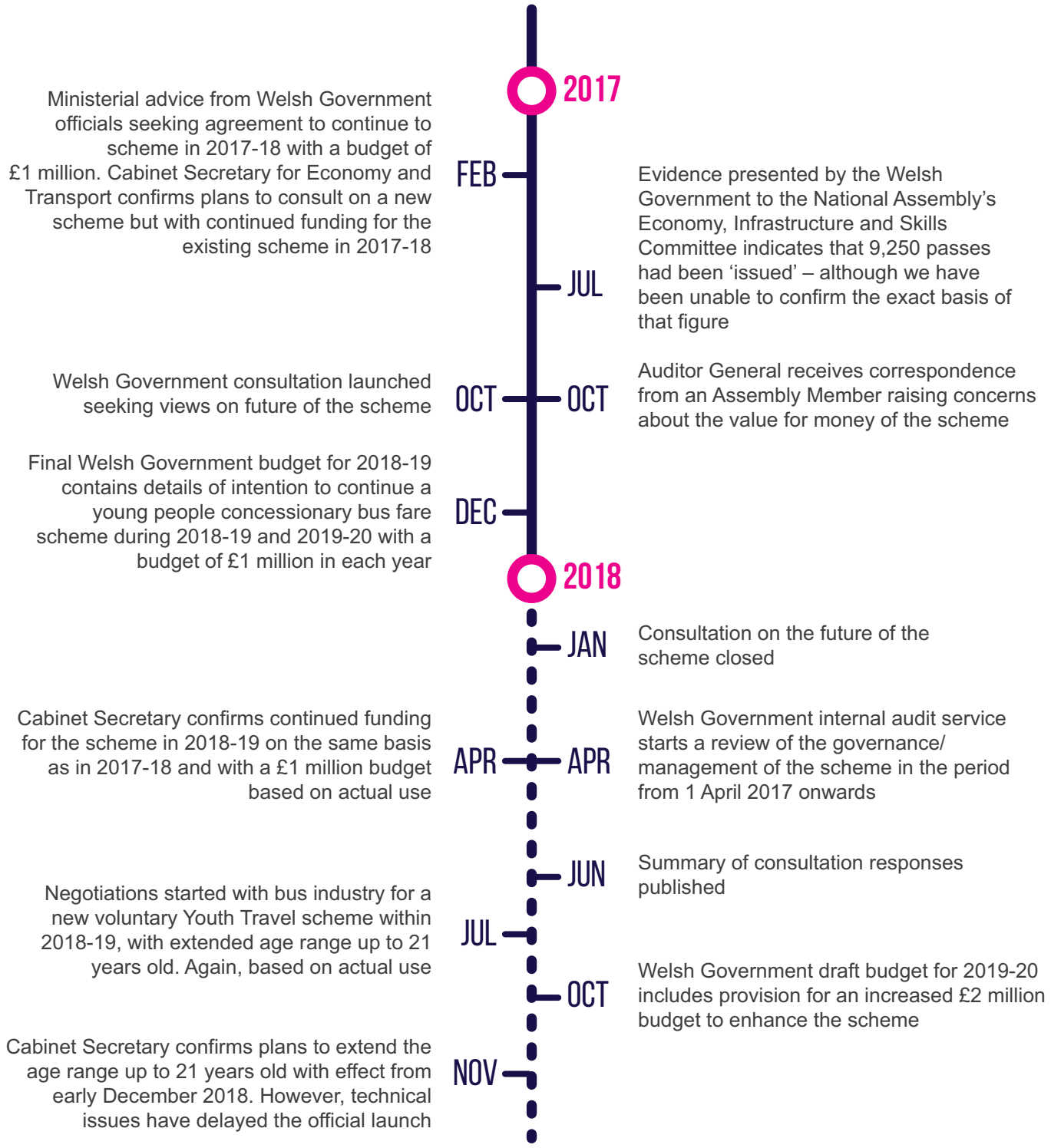
2016

JAN – Evidence presented by the Welsh Government to the National Assembly's Enterprise and Business Committee confirms that around 4,000 applications for passes had been received, from an eligible age cohort or around 110,000

MAR – Ministerial advice from Welsh Government officials seeking agreement to continue the scheme following approval of the final 2016-2017 budget

AUTUMN – Welsh Government starts negotiation with bus industry to continue scheme in 2017-18 but on an actual use basis

OCT – Draft Welsh Government budget for 2017-18 indicates removal of the specific budget line for the young people concessionary bus fare scheme


2017
Ministerial advice from Welsh Government officials seeking agreement to continue to scheme in 2017-18 with a budget of £1 million. Cabinet Secretary for Economy and Transport confirms plans to consult on a new scheme but with continued funding for the existing scheme in 2017-18
FEB
Evidence presented by the Welsh Government to the National Assembly's Economy, Infrastructure and Skills Committee indicates that 9,250 passes had been 'issued' – although we have been unable to confirm the exact basis of that figure
JUL
Welsh Government consultation launched seeking views on future of the scheme
OCT
OCT
Auditor General receives correspondence from an Assembly Member raising concerns about the value for money of the scheme
Final Welsh Government budget for 2018-19 contains details of intention to continue a young people concessionary bus fare scheme during 2018-19 and 2019-20 with a budget of £1 million in each year
DEC
2018
JAN
Consultation on the future of the scheme closed
Cabinet Secretary confirms continued funding for the scheme in 2018-19 on the same basis as in 2017-18 and with a £1 million budget based on actual use
APR
APR
Welsh Government internal audit service starts a review of the governance/ management of the scheme in the period from 1 April 2017 onwards
JUN
Summary of consultation responses published
Negotiations started with bus industry for a new voluntary Youth Travel scheme within 2018-19, with extended age range up to 21 years old. Again, based on actual use
JUL
OCT
Welsh Government draft budget for 2019-20 includes provision for an increased £2 million budget to enhance the scheme
Cabinet Secretary confirms plans to extend the age range up to 21 years old with effect from early December 2018. However, technical issues have delayed the official launch
NOV

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Llywodraeth Cymru
Welsh Government

Adrian Crompton
Auditor General for Wales
Wales Audit Office
24 Cathedral Road
Cardiff, CF11 9LJ

24 January 2019

Dear Adrian

Response to the Report of the Wales Audit Office on the Welsh Government's youth discounted bus travel scheme – 'MyTravelPass'

I welcome publication of the above report.

Officials led by Simon Jones, Director for Economic Infrastructure, worked closely with Matthew Mortlock and his colleagues in the production of the report, and I would like to thank Matthew and others for their thorough and inclusive approach.

I note that this is a fact-based report (without recommendations) that reflects the significant and substantial changes we made to the scheme after the end of the pilot phase, when the initial commitments ceased to apply.

You will be aware that the Welsh Government's internal audit service has additionally reviewed the scheme and those colleagues are already working with my team to deliver the actions identified in that report. Linked to that, my team have also discussed with your staff opportunities for further audit certification measures to validate funds received by local authorities and paid to the bus operators. This measure is being implemented to complement existing certification arrangements.

With best wishes

Andrew Slade
Director General
Economy, Skills and Natural Resources Group

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Document is Restricted

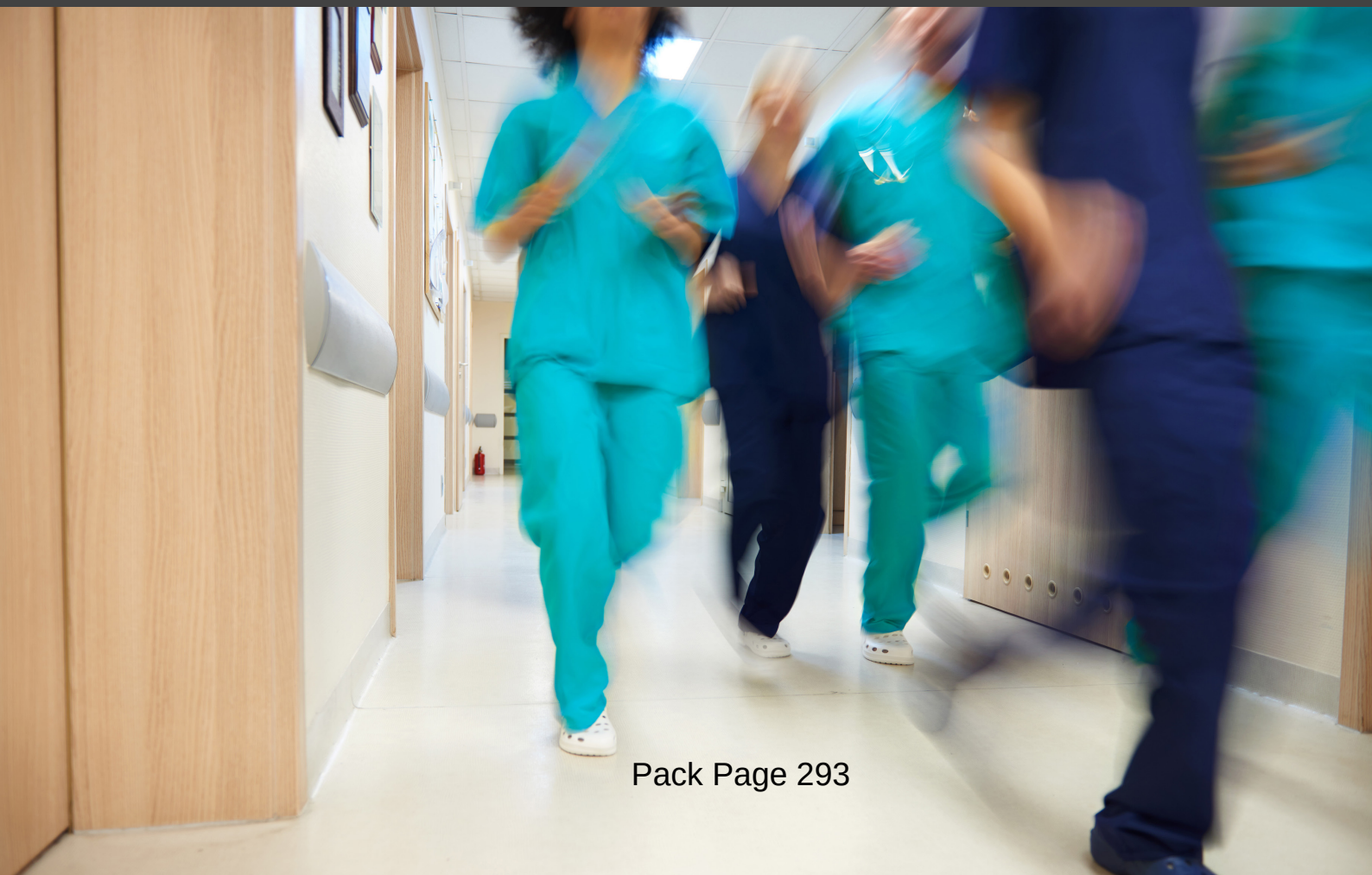
There is an interactive version of this document, please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

January 2019

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Expenditure on agency staff by NHS Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



This report has been prepared for presentation to the National Assembly under the Government of Wales Act 1998.

The Wales Audit Office study team comprised Nicholas Raynor, James Ralph, Nigel Blewitt and Huw Lloyd Jones under the direction of Mike Usher.

Wales Audit Office
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The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

Introduction

The NHS in Wales employs almost 80,000 full-time equivalent staff, excluding General Practitioners and those employed directly by General Practices, spending £3.62 billion on pay in 2017-18.

But NHS Wales also needs to use additional staff to supplement the full-time workforce so that they can continue to deliver services when:

- key posts are vacant;
- staff are on sick leave, on holiday or absent for some other reason; or
- demand for services increases because of, for example, winter pressures.

The seven Local Health Boards and three NHS Trusts (collectively referred to as health bodies in this report) secure the services of temporary staff from:

- substantive staff paid overtime to work additional shifts;
- internal staff banks, which typically include staff who have substantive contracts at the health body or at a neighbouring health body, as well as other suitably qualified staff who prefer to be able to choose where and when they work;
- private-sector agencies, who charge a fee for supplying staff; and
- people who enter into a direct contract with the health bodies on ad hoc terms of engagement. Some of these people may also have substantive contracts within the NHS.

Staff working on a temporary basis generally cost more for a shift than a person of the same grade who has a substantive contract. Staff supplied by agencies tend to be the most costly source of temporary staff. NHS bodies in Wales collectively spent over £160 million on agency staff in 2016-17, more than four times the equivalent figure for 2012-13. There have also been large increases in agency expenditure in other UK countries.

The scale and rapid growth of expenditure on agency staffing have created considerable media and public interest, not least because of the financial pressures faced by NHS bodies. NHS Wales has responded through a range of national and local initiatives aimed at reducing demand and controlling costs.

This report sets out key facts about the use of agency staff by NHS bodies in Wales, including:

- expenditure;
- analyses by health bodies of underlying reasons;
- national initiatives to control this type of spending; and
- challenges that lie ahead.

The report, together with the data tool we have developed, aims to:

- offer insight, enabling readers to conduct their own analyses; and
- promote improvement by sharing information about initiatives to curb spending on agency staff and highlighting issues for the NHS to consider when developing future initiatives aimed at managing agency expenditure.

It does not attempt to evaluate the use of agency staff or the effectiveness of the actions taken to control costs. This report and information gathered when preparing it will also be used to inform the planning of the Auditor General's forward programme of national and local audit work.

Agency expenditure in **2017-18**

£135.7m

Proportion of agency expenditure by staff group in **2017-18**

Medical and dental **44%**

Nurses and registered midwives **38%**

Other **18%**

Agency expenditure as a proportion of total NHS pay in **2017-18**

About **82%** of agency expenditure in **2018-19** is providing cover for vacant positions

Part 1 – Expenditure on agency staff by NHS Wales has increased markedly in recent years

Agency expenditure in 2017-18 was £135.7 million, a rise of 171% over seven years. (See Definition of agency expenditure on page 9). After a period of stability, it grew significantly after 2013-14, peaking at £164.4 million in 2016-17. (See Expenditure on agency staffing on page 10)

On average, health bodies in Wales have spent nearly half their total agency expenditure on medical and dental staff since 2014-15 and a further third on nurses and midwives. (See Distribution of agency expenditure on page 13)

Agency expenditure as a proportion of total pay increased from 1.6% of total pay in 2013-14 to 4.7% in 2016-17, before falling to 3.7% in 2017-18. (See Agency expenditure as a percentage of total pay expenditure on page 14)

Real term growth in total pay expenditure has outpaced the growth in staff numbers in recent years, reflecting the sharp increase in agency expenditure. (See Real-term growth in total pay expenditure and staff numbers on page 16)

Factors that have contributed to the rise in agency expenditure include:

- escalating hourly rates of pay charged by agencies and individuals engaged directly by health bodies;
- increase in demand for services;
- skill shortages;
- difficulties recruiting and retaining staff;
- meeting the requirements of the Nurse Staffing Levels Act (Wales) 2016; and
- individuals choosing to work through agencies.

But there is no national analysis of just how much each of these factors has contributed to the increase in agency spending. (See Factors that have contributed to increased agency expenditure on page 18)

Definition of agency expenditure

The definition of ‘agency expenditure’ in this report is set out below. It is the definition provided in Welsh Health Circular WHC 2018/017, ‘2018-19 LHB & Trust Monthly Financial Monitoring Return Guidance’ that is used by Local Health Boards (LHBs) and NHS Trusts (Trusts) to report on agency and locums (paid at a premium) expenditure in their monthly financial monitoring returns to Welsh Government.

Agency expenditure includes:

- staff not employed by the LHB or Trust and therefore not in receipt of payments through its payroll. This would include staff employed through Agencies, Self Employed Individuals etc.
- staff employed by another NHS organisation who are undertaking sessional work within the LHB or Trust, and again are not in receipt of payments through the LHB’s or Trust’s payroll for whom the work is being undertaken, which are paid at a premium.

Expenditure excludes:

- staff that are employed by the LHB or Trust, who undertake additional work on a temporary basis for another department within the same LHB or Trust or at another hospital site within the same LHB or Trust.
- any staff employed on a temporary basis or fixed term contract but who are in receipt of payment through a LHB’s or Trust’s payroll, on terms and conditions defined by that LHB or Trust.

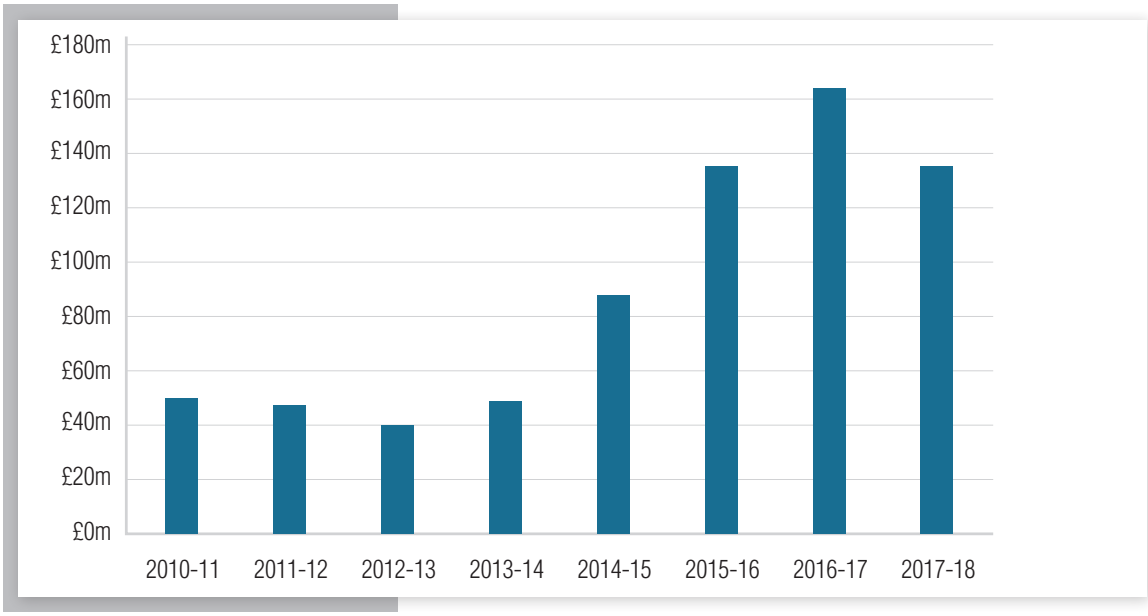
  Locums ‘paid at a premium’ are those paid above the rate of the substantive post holder.

The above definition, and all data in this report, exclude doctors and dentists who are General Practitioners, because they are independent NHS contractors. The analysis also excludes staff who are employed directly by General Practices.

Expenditure on agency staffing

Expenditure on agency staff was relatively stable until 2013-14, after which there was a sharp increase, with expenditure peaking at £164.4 million in 2016-17.

Exhibit 1: total NHS expenditure in Wales on agency staff between 2010-11 and 2017-18

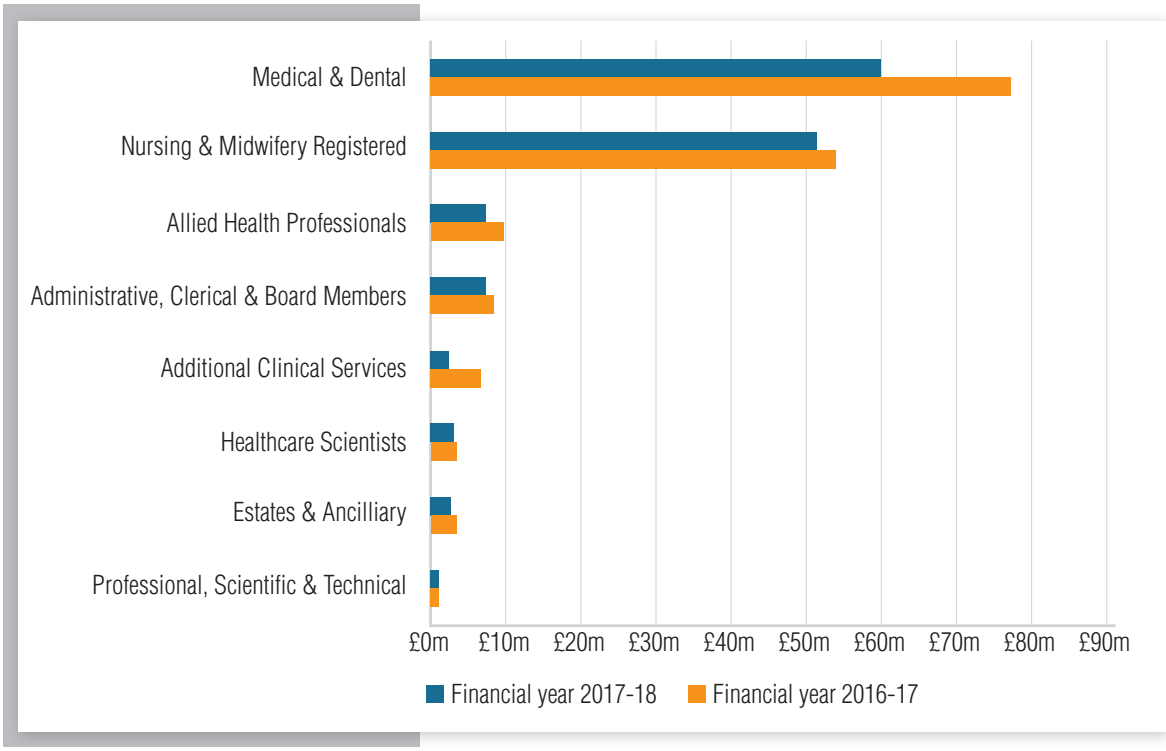


Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

This link opens a data tool that will allow analysis of expenditure on agency staff at each health body over the period 2010-11 to 2017-18. To access it please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

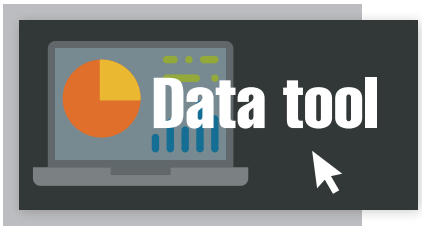
There was a fall in total agency expenditure in 2017-18 of £28.7 million. Expenditure fell in all staff categories except one.

Exhibit 2: NHS expenditure in Wales on agency staff by staff group for 2016-17 and 2017-18



Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

The largest reduction in expenditure was for Medical and Dental agency staff, where expenditure fell by over £17 million. There was a further reduction of £2.4 million in expenditure on Nursing and Midwifery agency staff. However, the scale of reduction varied widely between health bodies.



This link opens a data tool that will allow analysis of the changes in expenditure on the different agency staff groups at each health body between 2016-17 and 2017-18. To access it please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

A reduction in agency expenditure may be offset by increases in other elements of the NHS pay bill, but a breakdown of variable pay elements is not provided in the financial monitoring returns submitted by health bodies to Welsh Government.

The reported falls in agency expenditure may, in part, be because changes to the method of paying agency staff and locums result in expenditure falling outside the definition of agency expenditure in the monthly financial returns to Welsh Government.

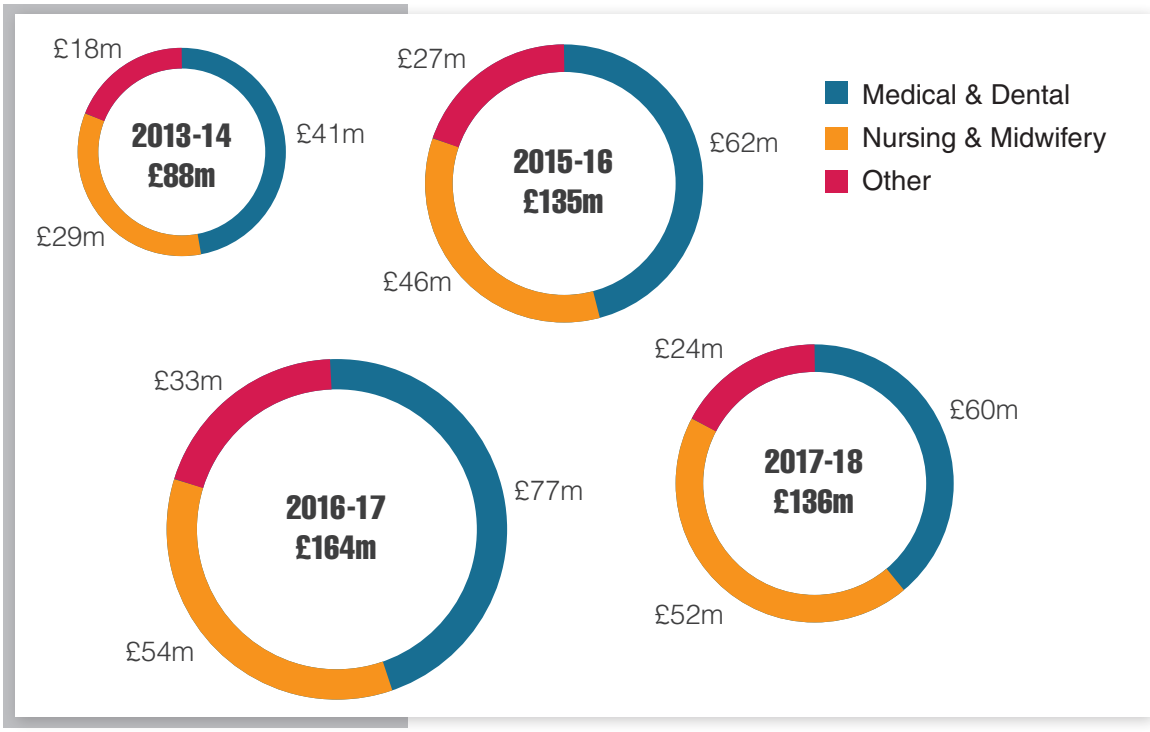
A national working group (the Medical Workforce Efficiency Group) is leading a project to improve the consistency of coding locum variable pay.

Distribution of agency expenditure

Health bodies use agencies to provide all types of staff, but expenditure on doctors and nurses represents about 80% of total agency expenditure.

Although total agency expenditure increased significantly between 2014-15 and 2016-17, Exhibit 3 shows that the proportion spent on each staff group has remained broadly constant.

Exhibit 3: the distribution of agency expenditure by staff group between 2014-15 and 2017-18



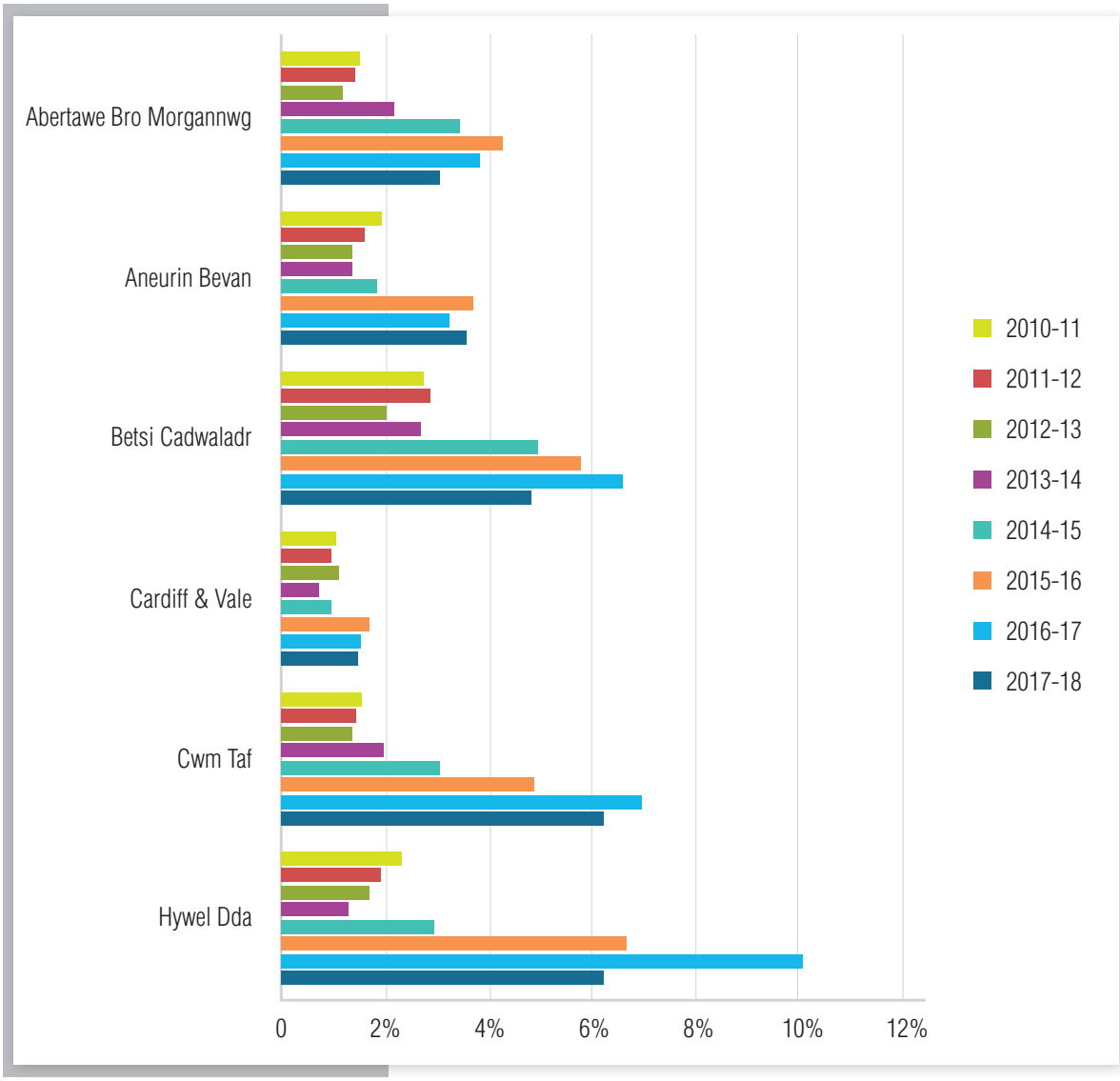
Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

Agency expenditure as a percentage of total pay expenditure

In 2010-11, expenditure on agency staff represented only 1.7% of total pay across the 10 health bodies in Wales. By 2016-17, the proportion had increased to 4.7%, before falling to 3.7% in 2017-18.

In most health bodies in Wales, there was a significant growth in expenditure on agency pay as a proportion of total pay between 2014-15 and 2016-17, followed by a small decrease in 2017-18.

Exhibit 4: total expenditure on agency staff as a proportion of total pay in the six largest health bodies in Wales between 2010-11 and 2017-18

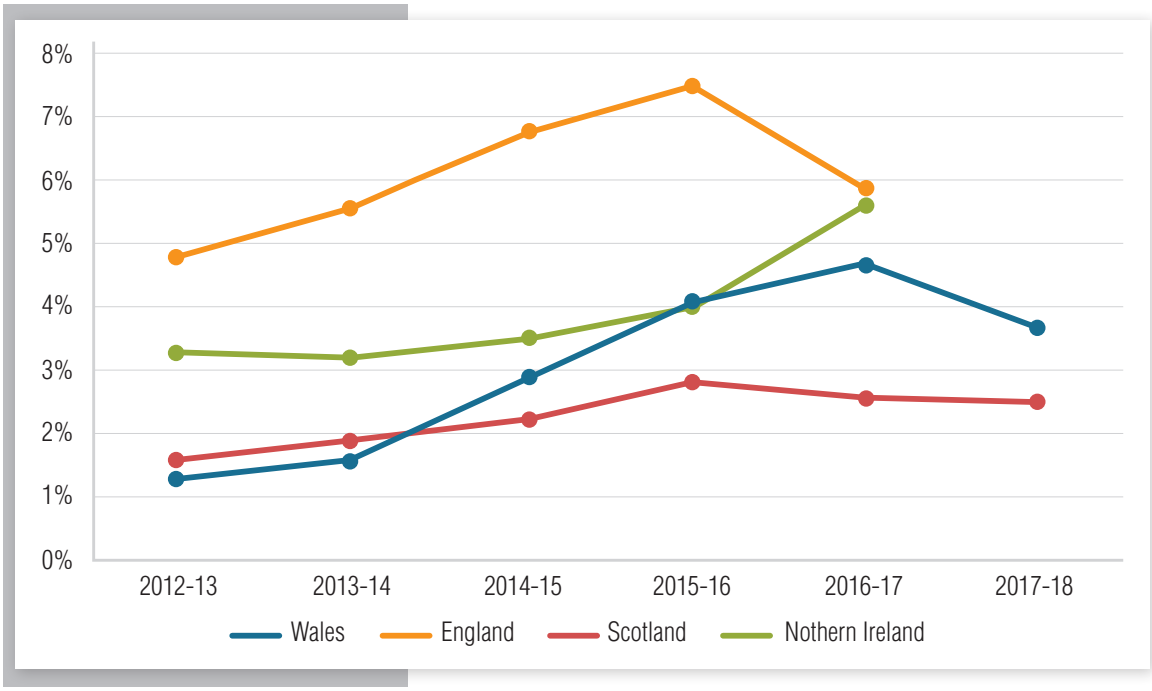


Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

This link opens a data tool that will allow analysis of total agency expenditure as a percentage of total pay expenditure at each health body between 2010-11 and 2017-18. https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

Significant increases in NHS expenditure on agency staff have not been confined to Wales, with high levels also being seen in England and Scotland. The scale of expenditure across the United Kingdom is different, but the trend in agency expenditure as a proportion of total pay expenditure is similar.

Exhibit 5: total agency expenditure as a proportion of total NHS pay in Wales, England, Scotland and Northern Ireland between 2012-13 and 2017-18



Note: The data for 2017-18 are not yet available for England and Northern Ireland.

Sources: Data received and collated by NHS Wales Shared Services Partnership, the National Audit Office, Audit Scotland and the Northern Ireland Audit Office from financial returns and accounts

Real-term growth in total pay expenditure and staff numbers

On 30 September 2017 the NHS in Wales employed almost 80,000 full-time equivalent staff, excluding General Practitioners and those employed directly by General Practices.

The composition of the workforce is shown in Exhibit 6.

Exhibit 6: number of full-time equivalent staff directly employed by health bodies in Wales by staff group on 30 September 2017

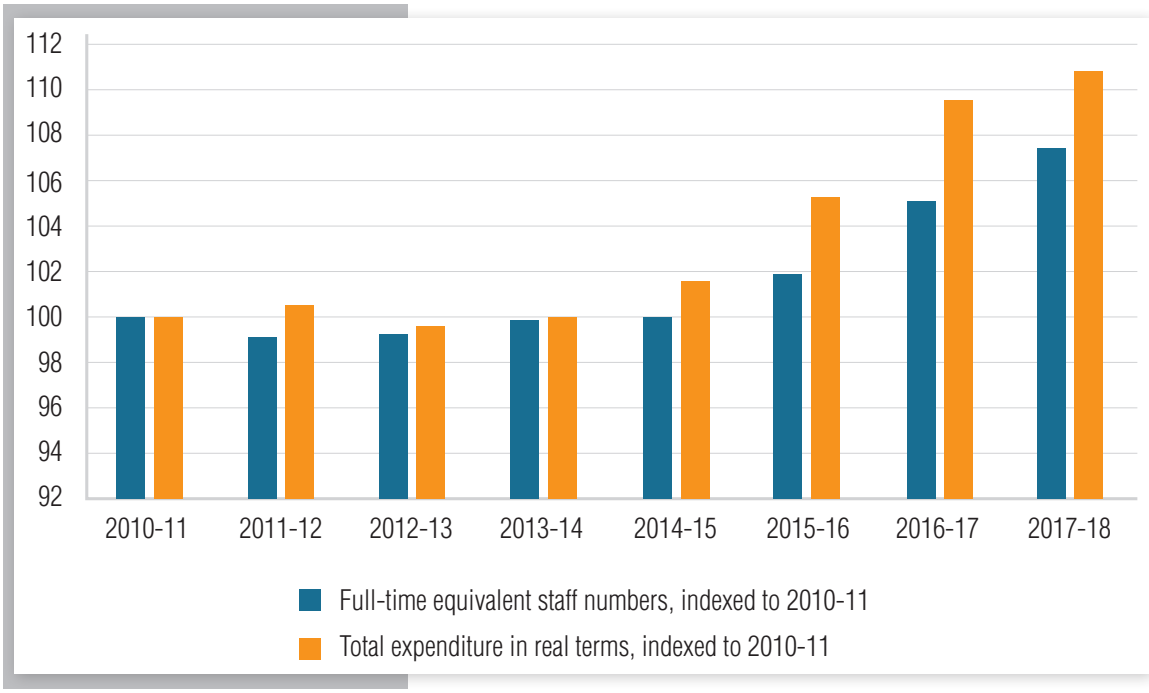
Staff group	Number of full-time equivalent staff at 30 September 2017	Proportion of workforce
Medical and dental staff	6,321	8.1%
Nursing, midwifery and health visiting staff	29,524	37.9%
Administration and estates staff	17,384	22.3%
Scientific, therapeutic and technical staff	12,799	16.4%
Health care assistants and other support staff	9,704	12.5%
Ambulance staff	2,084	2.7%
Other non-medical staff	101	0.1%
Total	**77,917**	**100%**

Source: NHS staff by staff group and year, StatsWales

The NHS workforce increased by 7.5% between September 2010 and September 2017. Medical and dental full-time equivalent staff numbers increased by 12.1% during this period and nursing, midwifery and health visiting staff increased by 4.7%.

Total pay expenditure increased from £2.92 billion in 2010-11 to £3.62 billion in 2017-18, an increase of almost 24% in cash terms. Exhibit 7 shows real-term growth in total pay expenditure since 2010-11 and compares it with the increase in full-time equivalent staff numbers. The graph shows that, from 2014-15, both staff numbers and total pay began to increase, with total pay in real terms accelerating more quickly than full-time equivalent staff numbers.

Exhibit 7: real-terms comparison of full-time equivalent staff numbers against total NHS pay expenditure in Wales between 2010-11 and 2017-18



Source: Wales Audit Office calculations, drawing on data provided by Workforce, Education & Development Services, NHS Wales Shared Services Partnership

The growth in total pay expenditure relative to staff numbers shown in Exhibit 7 cannot be explained by pay inflation among staff on substantive contracts, given that NHS staff have faced pay caps in recent years. Although not the only possible explanation, the growth in total pay is consistent with a significant increase in expenditure on temporary staff, whether via agencies or from other sources.

Factors that have contributed to increased agency expenditure

The increase in expenditure on agency staffing is due to a range of factors that include:

- escalating hourly pay rates;
- increases in demand for services and changes to the way in which health services are delivered;
- skill shortages;
- difficulties recruiting and retaining staff;
- levels of sickness absence;
- the need to comply with the requirements of the Nurse Staffing Levels Act (2016); and
- actions taken in England to drive down agency expenditure making it more attractive to agencies to focus more directly on the market in Wales.

We were told that increasing numbers of doctors and nurses choose to work for agencies or on a self-employed basis rather than being employed directly by the NHS.

Anecdotal evidence suggests that the lack of public sector pay growth has been a key factor for people registering with agencies for additional shifts or simply leaving substantive posts to work for an agency.

Findings published in the National Institute of Economic and Social Research report 'Use of Agency Workers in the Public Sector', produced in 2017, suggest that other factors attracting individuals to agency work include:

- valuing highly the preference for flexible working and improved work-life balance, with the opportunity to pick and choose shifts to suit their needs;
- dissatisfaction with working conditions and workloads within the NHS;
- being paid more quickly, as agencies generally make weekly payments; and
- younger generations attaching less importance to job security and pensions, and their desire to experience career breaks.

Part 2 – About 80% of agency expenditure is providing cover for vacant positions, but information on the number of agency staff used is limited

Financial projections by health bodies indicate that £90 million (77% of total forecast agency expenditure) will be spent to cover vacant posts in 2018-19.

For the first six months of 2018-19 about 82% of total agency expenditure was covering vacancies, with most of the remainder covering additional activity and sickness absence. (See Reasons for using agency staff in 2018-19 on page 20).

Each health body holds data on how many agency staff they use, and why. But there is still no all-Wales analysis of how many doctors, nurses and other staff are being hired through agencies, their specialties and their grades. The NHS is developing arrangements at an all-Wales level to better understand nursing and medical agency usage, which are the two largest areas of spend. (See Availability of information about agency staff used on page 21)

Reasons for using agency staff in 2018-19

The NHS in Wales has only recently begun to analyse at a national level the reason for each instance of hiring agency staff.

The financial position of individual organisations and the overall financial health of NHS Wales is monitored using monthly financial returns submitted by each health body to Welsh Government. Since April 2018 these financial returns require health bodies to provide an analysis of the reasons for incurring agency expenditure.

Most of those we spoke to in preparing this report were confident that the need to cover vacant posts accounted for most expenditure on agency staff. The financial returns by health bodies bear out this confidence.

- 77% of forecast agency expenditure for 2018-19, reported by health bodies at the end of April 2018, was to cover vacant posts; and
- 82% of the £66.8 million spent on agency staff during the first six months of 2018-19 was covering vacancies. Six per cent of the reported agency expenditure reflected the need to cover for sickness absence, while 8% was needed for additional activity.

Vacancies are reported at a national level based on ‘advertised’ posts. NHS Wales acknowledges that this reported data about the number and nature of vacancies is only a proxy for the true number of vacancies and does not give the true vacancy position.

Most organisations do not have a defined substantive staff complement to give a baseline to measure vacancies. Reporting vacancy rates based on ‘advertised’ posts can lead to:

- ‘double counting’ of vacancies because posts may be advertised more than once before they are filled; and
- vacant positions not being reported if the position is not being recruited to.

We found that, despite the reported link between agency expenditure and vacancies, there is no correlation between month-to-month changes in the number of advertised vacancies and corresponding fluctuations in agency spend.

Availability of information about agency staff used

Health bodies hold data on how many agency staff they use, who the individuals are and what they are used for. But this data is not collected in a common NHS-wide system, nor is it shared with other health bodies.

By not sharing information there is a risk that individuals may work excessive hours across different health boards, potentially putting patient safety at risk. Also, it is harder for NHS Wales to prevent fraudulent practices, such as people working for agencies whilst on sickness absence from their NHS employer.

Data produced at a national level on agency usage is limited but is developing. To better understand the use of agency doctors and nurses, which are the two largest areas of agency spend:

- spending data on agency nurses that is collected by a sub-group of the Temporary Nurse Staffing Capacity Steering Group is being converted to whole-time equivalent staff for each agency supplier since April 2017. This gives a better understanding of the volume of agency staff engaged as well as the cost. However, the data is collected independently of the financial monitoring returns submitted by health bodies to Welsh Government and is not consistent with the agency spend reported by Welsh Government.
- health bodies are submitting data about their use of agency and locum doctors to Welsh Government following the introduction of Welsh Health Circular 2017-042 ‘Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales’ in October 2017 (see National Initiative – Controlling the cost of medical and dental agency staff on page 26 for detail on the Circular). However, the data reflects ‘bookings’ made in the month rather than expenditure incurred. The bookings may be worked and paid for over a period covering more than one month or may not be worked in full if it is a ‘call off’ booking.

Part 3 – NHS Wales is seeking to reduce the demand for agency staff as well as controlling the price it pays for them

In seeking to reduce agency expenditure, NHS Wales bodies generally deploy a two-pronged combination of:

- reducing the need to hire agency staff; and
- where they are hired, paying less than before to do so.

NHS managers generally hire agency staff only as a last resort. Initiatives at individual health bodies to reduce the demand for agency staff focus mainly on: recruiting and retaining more staff; reducing sickness absence; and improving rota management and job planning.

NHS Wales has put in motion a number of national workforce initiatives aimed at increasing the attraction of the health service as an employer and therefore reducing the demand for agency staff. (See National workforce developments on page 23)

The demand for agency staff has fuelled competition between health bodies and driven up rates of agency pay, particularly in areas of skill shortages. Health bodies are working together via all-Wales working groups to control the cost of using nursing and medical agency staff. In this report we profile two national initiatives:

- the introduction in 2017 of capped rates of pay for nursing agencies with a focus on eradicating 'off-contract' agency usage, led by the Temporary Nurse Staffing Capacity Steering Group. (See National Initiative – Controlling the cost of nursing agency staff on page 24)
- the introduction of arrangements in November 2017 to drive down both the volume of medical and dental agency and locum use and its cost, which took account of detailed work undertaken by the Medical Workforce Efficiency Group. (See National Initiative – Controlling the cost of medical and dental agency staff on page 26)

This link opens a data tool that will allow analysis of expenditure on Medical & Dental and Nursing & Midwifery agency staff at the six largest health bodies between 2012-13 and 2017-18. To access it please visit https://www.audit.wales/publication/expenditure-agency-staff-nhs-wales

National workforce developments

National workforce developments and initiatives aimed at increasing the attractiveness of NHS Wales as an employer, and therefore reducing the demand for agency staff, include:

- the recent creation of the special health authority Health Education and Improvement Wales whose key functions include: education and training, workforce development and modernisation, leadership development, strategic workforce planning, workforce intelligence, careers and widening access.
- the campaign to attract high calibre health professionals by promoting Wales as an excellent place for doctors and dentist to train. The campaign[1] promotes initiatives such as:
  - the Less Than Full-Time Training policy;
  - the Wales Clinical Academic Track (WCAT) scheme; and
  - the new education contract for junior doctors which ring-fences time for learning opportunities during the working week to support career development, a UK first.
- The Train Work Live national campaign launched in 2016 to promote Wales as an attractive place to work for GPs and other doctors.
- The recent pay agreements for the NHS Wales workforce. The pay deals agreed for doctors, nurses and other NHS staff include a range of pay and non-pay measures aimed at providing better terms and conditions for NHS Wales staff and thereby improving recruitment and retention within the workforce.

1 https://www.walesdeanery.org/future-doctors-and-dentists-–-come-and-train-wales/future-doctors-and-dentists-–-come-and-train

National Initiative – Controlling the cost of nursing agency staff

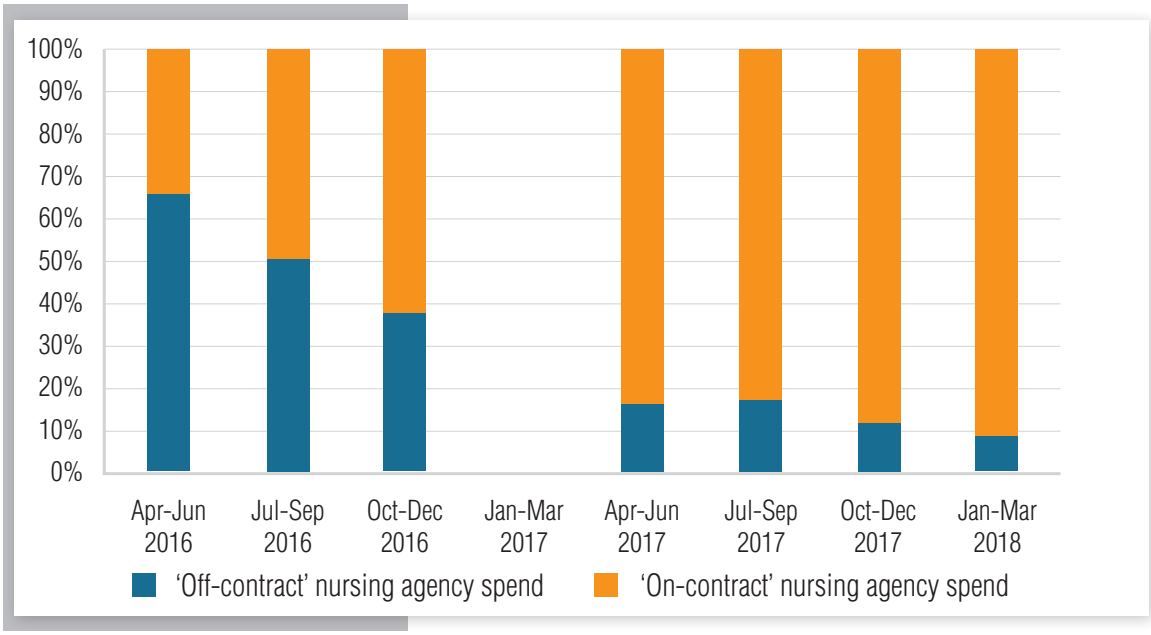
Framework agreements for supplying agency nurses have been in place since 2006. Such agreements avoid the need for each health body to conduct procurement exercises before hiring agency staff. The current All Wales Agency Framework Contract came into effect on 1 April 2017 and introduced capped hourly rates of pay to nursing agencies. The contract has a duration of 24 months with the option to extend for up to a further two years.

Suppliers of agency nurses through a framework contract are referred to as 'on-contract' agencies. Agencies that are not part of a framework contract, referred to as 'off-contract' agencies, generally have a higher hourly charge to health bodies than 'on-contract' agencies.

The Temporary Nurse Staffing Capacity Steering Group was set up in 2015 to explore how health bodies in Wales can work together to address the growing concern over high cost and escalating nursing agency spend. The group aims to eradicate the use of 'off-contract' agencies to meet the demand within NHS Wales for temporary nurses.

Exhibit 8 shows there has been a reduction in the proportion of nursing agency expenditure. 'Off-contract' agency spend across Wales fell from 65% at the beginning of the 2016-17 financial year to an average of 14% for the 2017-18 financial year.

Exhibit 8: proportion of nursing agency expenditure spent with 'off-contract' and 'on-contract' agencies



Note: Data for the period January 2017 to March 2017 is not available.

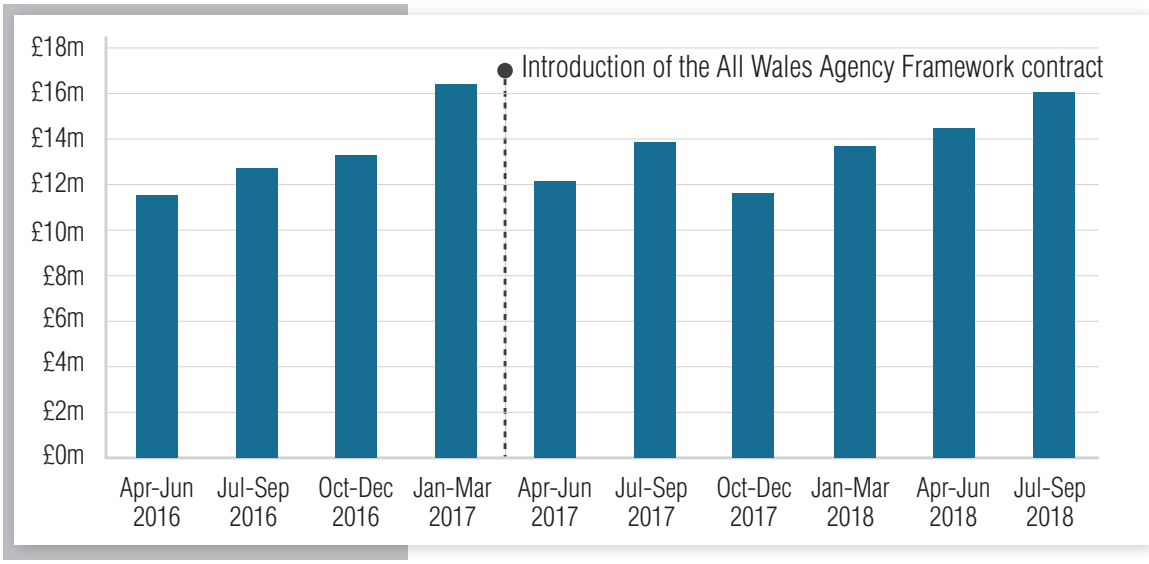
Source: NHS Wales Shared Services Partnership

We were told that two main factors have been instrumental in achieving this significant and consistent decrease in the use of 'off-contract' nursing agencies:

- the commitment from health bodies to use agencies on the framework contract as much as possible and not to breach the contract's capped rates; and
- setting capped rates that are deemed to be good but not excessive so that the framework contract can supply the agency nurses needed.

Despite the success in reducing the proportion of 'off-contract' agency expenditure, Exhibit 9 shows that agency expenditure on nurses and midwives in the first two quarters of 2018-19 is greater than it was in the corresponding periods in 2016-17 and 2017-18. Data is not available to fully explain the reasons for expenditure increasing.

Exhibit 9: expenditure on Nursing and Midwifery Registered agency staff from April 2016 to September 2018



Source: Source: Workforce, Education & Development Services, NHS Wales Shared Services Partnership

National Initiative – Controlling the cost of medical and dental agency staff

Welsh Government issued Welsh Health Circular 2017-042, 'Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales' (the Circular) in October 2017.

The Circular sets out the arrangements for:

> **'a programme of coherent and coordinated system-wide action across the NHS in Wales aiming to drive down agency and locum deployment and expenditure whilst maintaining the delivery of a safe and sustainable service across Wales'.**

The programme aims to:

> **'encourage return of people to the NHS labour market so improving regular workforce supply and quality and consistency of care to patients; increasing the equity and transparency of reward systems and reduction of internal wage competition; and reduce the overall spend whilst we focus on the underlying causes'.**

The Circular was developed by Welsh Government in partnership with the NHS in Wales, taking account of detailed work undertaken by the Medical Workforce Efficiency Group. This group was established in 2017 with aims and objectives that, if achieved, should reduce both reliance on and cost of agency doctors across NHS Wales. The membership of this group is drawn from Welsh health bodies and NHS Wales Shared Services Partnership.

The Circular sets out a national control framework of limits and targets for agency and locum deployment and expenditure, clearly defining the respective roles and responsibilities of Welsh Government and health bodies, and setting out a performance management regime at local and national levels.

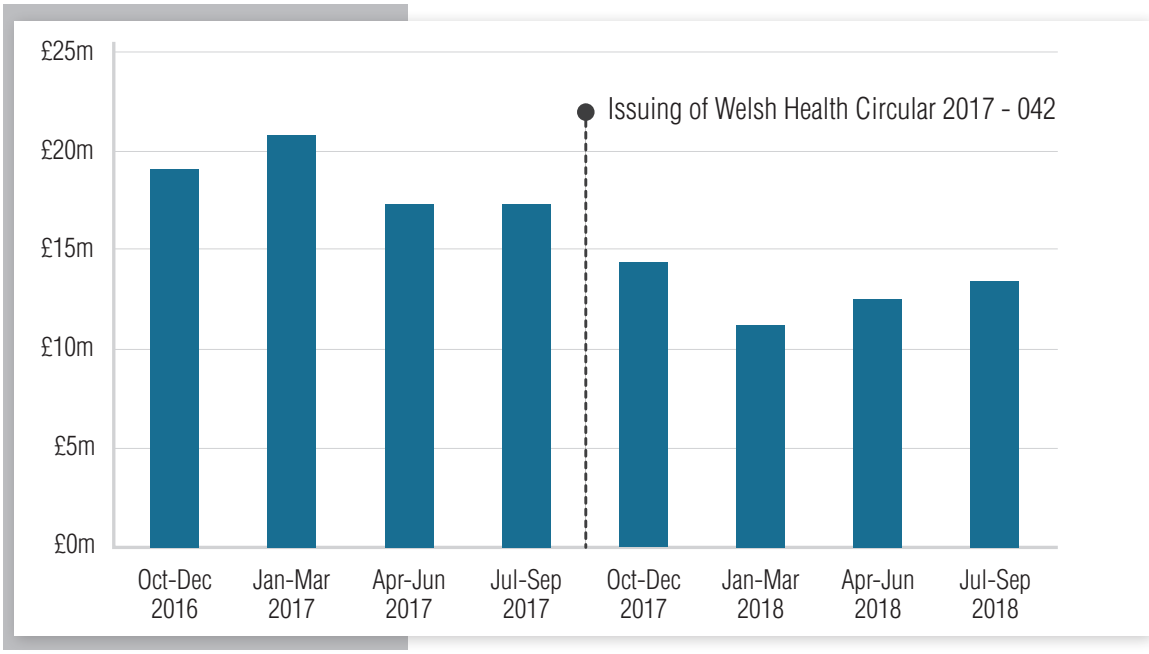
A key feature of the control framework is the introduction of price caps for all medical and dental agency workers. The framework includes provision for health bodies to override the price caps under prescribed circumstances, which is not the case for nursing agency staff.

The Circular has improved controls over the authorisation of expenditure. The price caps can only be breached following internal escalation processes that require authorisation at Executive level following a robust risk assessment of the impact on patient safety.

The Circular refers to the establishment of a Workforce Delivery Unit to provide central capacity for scrutiny, identifying and sharing effective practices and targeted interventions to tackle specific issues or priorities. The Workforce Delivery Unit would also analyse the monthly data returns submitted by health bodies on medical and dental agency usage set out in the Circular 2017. The Workforce Delivery Unit had not been established at the end of our fieldwork.

Exhibit 10 shows that since the introduction of the Circular in November 2017, expenditure on medical and dental agency workers has reduced. However, the lack of data available means that NHS Wales is unable to ascribe the entire fall in expenditure to the impact of the Circular. Other factors may have contributed to this reduction, such as the hiring of fewer staff and the use of alternative temporary staffing solutions.

Exhibit 10: expenditure on Medical and Dental agency staff from October 2016 to September 2018



Sources: Workforce, Education & Development Services, NHS Wales Shared Services Partnership, and Welsh Government

Part 4 – We identified two key challenges to improving the management of agency staffing expenditure

This report does not attempt to evaluate the effectiveness of the actions taken to control the use of agency staff. However, we have identified two factors that we consider key to underpinning the management of agency expenditure in the wider context of temporary staffing across NHS Wales.

1 To gain a deeper understanding of the root causes of agency spend NHS Wales needs consistent and comparable data at an all-Wales level on:

- the volume, nature and cost of agency staff used; and
- the impact of changes in agency expenditure on other temporary staffing costs, such as overtime and internal staff banks. (See Developing all-Wales information to better understand and manage agency expenditure and usage on page 29)

2 The working groups established by NHS Wales to reduce nursing and medical agency costs are delivering much of what they set out to achieve. But the next steps in managing agency expenditure are expected to require the consistent implementation of difficult decisions across Wales. To achieve this, future projects to manage agency and other temporary staffing expenditure will therefore need strong leadership and the capacity to drive change in a timely fashion. (See Leadership of future initiatives to manage agency and other temporary staffing expenditure on page 30)

Developing all-Wales information to better understand and manage agency expenditure and usage

Information on agency cost and usage at a national level is limited. Data is held by individual organisations but is not easily accessible in a consistent form.

We consider that action to further develop two data-related themes is necessary to manage agency expenditure more effectively at a national level.

1

The ability to access and share consistent and comparable data held by individual NHS organisations at an all-Wales level.

This will allow information to be produced that is detailed enough to understand and explain:

- the volume of agency staff used;
- the frequency and regularity with which they are used;
- the roles they fill;
- the reason for needing them; and
- the cost.

Such information has the potential to inform and significantly enhance workforce planning across NHS Wales.

2

The ability to assess agency spend and usage data in the context of other temporary staffing costs.

A fall in agency spend or usage may lead to increases in other areas of temporary staffing such as overtime and internal bank working.

NHS Wales needs to be capable of evaluating reductions in agency expenditure and fully understanding consequential changes in agency expenditure on other forms of temporary staffing.

Leadership of future initiatives to manage agency and other temporary staffing expenditure

The Temporary Nurse Staffing Capacity Steering Group and Medical Workforce Efficiency Group have made positive contributions to reducing agency expenditure and are delivering much of what they set out to achieve. The groups rely heavily on the commitment of members and on partnership working. But, at times progress with developing and implementing change is hampered by:

- difficulties in reaching consensus before making decisions; and
- the lack of staff capacity to carry out work outside meetings of the groups.

In our view, a step change is needed to drive forward projects focusing on managing temporary staffing expenditure with greater pace and consistency.

Future national projects that are set up to manage expenditure on agency and other temporary staffing, such as developing the capacity and usage of staff banks, will need:

- leadership of sufficient seniority and membership of sufficient authority to make difficult decisions and drive change in a consistent way across the whole of NHS Wales;
- the financial, staffing and technological support needed to support and deliver the work; and
- a structure that is closely linked with wider workforce planning considerations.

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